



**UNITED STATES ARMY
ENVIRONMENTAL HYGIENE
AGENCY**

ABERDEEN PROVING GROUND, MD 21010-5422

OCCUPATIONAL HEALTH PROGRAM MANUAL

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Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) to Commander, US Army Environmental Hygiene Agency, ATTN: HSHB-OM Aberdeen Proving Ground, MD 21010.

This guide was prepared by Miss Edna May Klutas, Nurse Consultant, Occupational and Environmental Medicine Division, who has since departed from this Agency.

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CHAPTER 1
GENERAL

Section I. Introduction

1-1. General.

a. Purpose. The purpose of this guide (hereinafter referred to as the manual) is to:

(1) Provide direction for a systematic approach to plan, develop, maintain, and/or improve and evaluate an occupational health program for military and civilian employees.

(2) Facilitate the development and use of sound, uniform occupational health practices that are consistent with legal and regulatory requirements and with recognized medical and nursing principles.

(3) Provide a ready reference for personnel newly assigned to occupational health activities.

(4) Stimulate and encourage installation personnel to provide an optimal OHP based on identified needs and priorities.

b. Scope. The manual identifies the legal and regulatory bases and content of the OHP. It also provides organizational and administrative guidance, identifies sources of assistance or support, and gives other information pertinent to implementation of the OHP.

c. Applicability.

(1) Although written primarily for Active Army, US Army National Guard, and US Army Reserve elements, the manual is also applicable to Defense Logistics Agency activities serviced by DA medical treatment facilities IAW AR 40-3 and AR 40-5. Where indicated, specific DLA regulations, forms, or other references are identified.

Note. The terms "he," "she," "his," "hers," "him" and "her" as used in this guide are interchangeable and are intended to include both masculine and feminine genders; any exceptions to this will be so noted.

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(2) Not all of the manual will be applicable to every installation since each OHP must be tailored to the specific needs, resources, capabilities, and limitations of the installation it serves. Therefore, with the exception of those program elements required by regulation, the manual should be used, not as a measure of success or failure, but as a source of ideas and suggested methods for accomplishing the best possible program for the particular installation.

1-2. Organization of manual. The considerations, resources, and procedures involved in establishing an occupational health program are presented step-by-step. References (app A), abbreviations (app B), glossary (app C), resource materials, forms, and detailed instructions, where applicable, are contained in the appendices.

1-3. Maintenance of manual. Placement of the manual in a loose-leaf binder will facilitate insertion of changes or additions. Users of the manual are encouraged to submit recommendations for changes and comments to improve the guidance contained in the manual. Comments should be keyed to the specific page, paragraph, and line of text for which the change is recommended. Reasons should be provided for each change to insure understanding and complete evaluation. Comments should be prepared using DA Form 2028 (Recommended Changes to Publications and Blank Forms) and directed to Commander, US Army Environmental Hygiene Agency, ATTN: HSE-OM, Aberdeen Proving Ground, MD 21010.

1-4. Definitions. Explanations of terms, as used in this manual, are found in Appendix C.

1-5. Technical assistance.

a. Additional assistance and guidance in implementing the occupational health program are available from the US Army Environmental Hygiene Agency on request through command channels.

b. CONUS requests for assistance should be addressed to Commander, US Army Health Services Command, ATTN: HSPA-P, Fort Sam Houston, TX 78234.

c. Overseas requests should be addressed to HQDA (DASG-PSP), Washington, DC 20310.

Section II. Background Information:
Department of Army Occupational Health Program

1-6. Authority and regulations. Various laws and regulations have been promulgated to promote the health and effective performance of Federal employees through establishment of occupational health programs.

a. The laws and Federal directives authorizing occupational health programs for Army civilian and military employees include the following:

(1) Public Law (PL) 79-658, Health Programs for Government Employees, as amended (5 USC 7901, 1946), provides for emergency treatment of on-the-job illnesses, pre-employment and other examinations, referral of employees to private physicians, and preventive programs relative to health.

(2) Bureau of the Budget Circular No. A-72, Federal Employees Occupational Health Service Programs, 18 June 1965, authorizes funding and establishes criteria for developing occupational health programs.

(3) PL 91-596, Occupational Safety and Health Act of 1970 (OSHA), 29 December 1970, 29 USC 651 et seq., requires employers to provide a safe and healthful working environment for all employees. Implementing regulations and standards for the Act are published under Title 29, Code of Federal Regulations (CFR), Part 1900-1999. Executive Order 12196, Occupational Safety and Health Programs for Federal Employees, 26 February 1980; and Title 29, CFR, Part 1960, Basic Program Elements for Federal Employee Occupational Safety and Health Programs, define OSHA's applicability to the Federal government and specify establishment of an occupational safety and health program. Department of Defense Instructions direct implementation of the program for military and civilian employees of DOD.

(4) Bureau of the Budget Circular No. A-11, Preparation and Submission of Budget Estimates, May 1978, requires that funding for occupational health and safety be identified as a separate line item on the health programs budget estimate.

(5) Federal Employees' Compensation Act of 7 September 1916 (5 USC 7901 et seq.) and 20 CFR, Chapter 1, Office of Workers' Compensation Programs, Department of Labor, provide for treatment and compensation for civilian workers incurring job-related injuries and illnesses.

b. Regulations on the occupational health program include AR 40-5; various chapters of the Federal Personnel Manual (FPM) such as 339, 792, 810, and 930; and USA Health Services Command (HSC) Regulation 11-4, HSC Operating Program - Preventive Medicine Guidelines for Implementation of a Preventive Medicine Program for MEDCEN/MEDDAC. More complete listing of applicable DA and HSC regulations is found in Appendix A-1. DLAM 1000.1,

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DLA Safety and Health Manual, defines the occupational health program for DLA personnel.

1-7. Objectives and scope of the Army occupational health program.

a. The objective of the occupational health program is to promote the health and efficiency of Army military and civilian employees. The Federal Government has acknowledged the importance of good health as a factor in employee efficiency and productivity, and that health maintenance is the responsibility of both the worker and the employer. It is primarily the responsibility of the worker to take proper care of his own health. The Federal Government, on the other hand, must provide a safe, healthful work environment; assure that all civilian and military employees are physically and psychologically suited to their work; and, through preventive measures, foster health and diminish illness or injury arising from the worker-job relationship.*

b. As defined in AR 40-5, the scope of the occupational health program shall include:

(1) Evaluation and control of the health hazards and physical stresses of the work environment and promotion of necessary measures to assure the health and safety of workers within that environment.

(2) Assure all workers are physically, mentally, and psychologically suited to their work through initial and periodic medical examinations related to job hazards and physical requirements.

(3) Medical care for occupational illnesses and injuries, and emergency and limited palliative care for nonoccupational illnesses and injuries with referral to the workers' personal physicians.

(4) Job related and general health counseling and education.

(5) Health maintenance measures such as job related surveillance of pregnant employees and personnel with chronic disabilities, medical/nursing support of the sickness absence control program, immunization programs, and voluntary health examinations or disease screening programs.

(6) Maintenance of medical records and reports.

(7) Analysis and interpretation of statistics and services.

* "Statement by The President to the Cabinet on New Guidelines for Employee Health Services," The White House, Washington, DC, 18 June 1965, p 2, and Executive Order 12196, Occupational Safety and Health Programs for Federal Employees, 26 February 1980.

1-8. Priorities of medical care. AR 40-3 defines priorities for providing medical care to military and civilian employees. This gives first priority to all care of military personnel on active duty and job-related health examinations and services for civilian employees. These occupational health services are to be provided before dependent and retiree care. HSC Pamphlet 40-2 further identifies priorities for occupational health services in accordance with existing laws and regulations. When required care is not within the capabilities of the MTF, arrangements shall be made to procure the care from other Army or Federal MTF (preferred choice) or from civilian sources. In the latter instance, charges for services shall be paid from the Army MTF operating funds (AR 40-3). The method of choice shall be determined IAW professional considerations and economy of funds and time.

1-9. Department of Army administrative organization and channels for the occupational health program. A description of organizational structure of the Army as it relates to the occupational health program is provided in Appendix D. Focusing on the Army Medical Department (AR 10-5), the Appendix summarizes the organization and responsibilities of the major DA elements at MACOM and installation levels. Detailed guidance on the occupational health service organization and administration is found in chapter 4.

CHAPTER 2
OCCUPATIONAL HEALTH PROGRAM DEVELOPMENT

Section I. Introduction

2-1. General. The minimal OHP for Federal personnel has been defined by law. Methods of complying with the law and other regulatory requirements must vary IAW specific needs and resources of each installation. Therefore, planning appropriate occupational health programs and services by the physician in charge of the OHP (or by the OHN coordinator) must be based on careful initial and continuing assessment of the installation, its mission, the personnel, and available resources.

2-2. Stages of program development. Figure 2-1 illustrates a systematic approach to program planning and development. It is applicable whether a new comprehensive OHP is being initiated or only a new activity or service within an existing program is planned. Chapters 2 and 3 of the manual follow this system in describing the development and implementation of the occupational health program. Data collection and its evaluation is discussed in sections II and III, followed by development of the OHP plan (sec IV). The actual OHP implementation and evaluation is presented in detail in chapter 3.

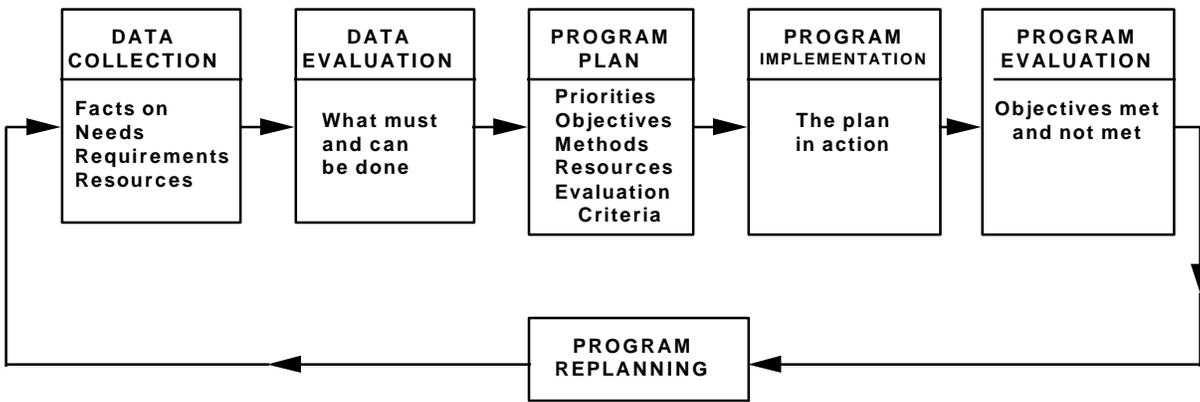


Figure 2-1. Stages for Occupational Health Program Development

Section II. Data Collection

2-3. General.

a. One of the first steps in program development is identification of occupational health needs and resources based on collection of pertinent factual data concerning the installation, its operations and activities, its populations and its resources. The method of data collection and recording is closely related to the subsequent assessment and use of the data in program development. The type of information to be gathered and maintained and the anticipated frequency for its revision and/or use should determine the most efficient way to record and store the data. Tickler-card files can be quite effective when data are not too complicated, when they are changed often, or when there is frequent referral to the data. Automated data systems, where available, provide a highly efficient means of storing, retrieving, and analyzing data.

b. Data shall be collected for all potential recipients of occupational health services. For example, MTF usually provide medical support not only for the installation on which they are located, but also for all other Army and Federal agencies located on the installation and, occasionally, for other nearby Federal agencies. This medical support may range from only emergency treatment to the full scope of services available at the MTF, to include routine occupational health services. Occasionally, local letters of agreement are developed when there are special support requirements. These are maintained by the Management Officer or Comptroller and/or Plans, Operations, and Training Office at the MTF. In addition, union agreements may cite specific health care requirements that may influence the occupational health planning. So far as is feasible, the occupational health physician and/or nurse should review such agreements prior to their finalization when they include occupational health factors. The purpose of this medical review is to insure that desired services can be provided and that they are in conformity with legal requirements and sound medical practices. All installation support agreements should be reviewed so that appropriate data can be collected on all agencies or activities that will be receiving occupational health services.

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2-4. Inventory of potential occupational health hazards (OHH).

a. Responsibility. A comprehensive listing shall be developed and maintained of all installation chemical, physical, biological, and psychological hazards potentially dangerous to the health of exposed military and civilian personnel, and of positions having specific standards for medical fitness of the employee. Development of the Local Occupational Health Hazard Inventory (LOHHI) is the responsibility of industrial hygiene personnel. Identification of positions with physical fitness requirements is the responsibility of personnel officers in coordination with the OHMD and with supervisors and/or safety, when indicated. The physician in charge of (or consultant to) the occupational health program is responsible for health aspects of the inventory (i.e., the definition of the types, scope, and frequency of medical surveillance required). The LOHHI will be maintained by the onsite industrial hygienist or technician, and a copy kept available in the occupational health unit, along with the list of positions requiring physical fitness.

b. Content. The initial hazards inventory will usually be quite simple. It results from walk through inspections of each worksite with information collected by location and operation, and recorded on HSC Form 403R, Local Occupational Health Hazard Inventory (LOHHI) (fig 2-2a) and HSC Form 403a R, Army Occupational Health Hazard Inventory (LOHHI II) (fig 2-2b). As a minimum, the inventory should list the chemical, physical, and biological hazards present; protective equipment or controls used; and the number of people potentially exposed. This baseline inventory is then refined over time as industrial hygiene, safety, and radiation surveys generate more complete data on exposure levels associated with certain tasks or individuals. These data may then be gathered into a composite inventory for all operations at each installation or the LOHHI's may be filed by location (building and operations). DD Form 1813 (Material Safety Data Sheet) (fig 2-3) will be used to provide essential data on the chemicals used at the installation. In addition to collecting hazard data by surveys, PVNTMED, the OHS, and/or safety shall be kept informed promptly about any changes in operations, processes, or mission so these may be reflected in the LOHHI and appropriate preventive measures taken as indicated. It is important that supervisors be made aware of the reason for the LOHHI and their responsibility to notify occupational health personnel when changes are planned or made. The objective is to collect and maintain enough exposure and work history/experience data to accurately evaluate which workers are genuinely at increased risk and which are only minimally exposed. This permits more efficient and effective use of medical resources through focusing the scope of the examinations on the potential health effects of the individual's job.

LOCAL OCCUPATIONAL HEALTH HAZARD INVENTORY (LOHHI)

1. INSTALLATION/ACTIVITY - ABD Army Depot	
2. BLDG - 200	3. BAY/SECTION/OTHER - C
4. DIRECTORATE/DIVISION/UNIT/OTHER - DPAE	
5. DATE COLLECTED - 29 October 1981	6. EVALUATOR - J. Jump
7. SUPERVISOR/POC/OTHER - E. Stern	
8. OPERATION - Welding and soldering of mild steel, aluminum, bronze, stainless steel, and galvanized metals	
9. EXPOSURES - Ozone, intense visible light, metal and flux fumes, cadmium, lead, zinc chloride flux, zinc oxide	
10. CONTROLS - Local exhaust collection, gloves, apron, goggles (tinted), respirator (TC-90-101), medical monitoring	
11. NUMBER OF PEOPLE - a. Military <u>2</u> b. Civilian <u>6</u> c. Total <u>8</u>	
12. STATUS OF CORRECTIVE ACTION Recommendation to upgrade LEV was made on last survey. No action has been taken to date.	
13. REMARKS a. Controls Required: Site 2: LEV needs to be upgraded to provide minimum of 100 fpm capture velocity.	

SAMPLE

NSC Form 4094 (REV. 11-80) 1-81-79

Figure 2-2a. Example of LOHHI (Industrial Hygiene Copy)

ARMY OCCUPATIONAL HEALTH HAZARDS INVENTORY LOHHI II FIELD FORM MAY 1983 (see AFCE Para 4-3.1)							
REGULATION: ABD Army Depot				BUILDING / ROOM: 309			
INVENTORY DATE: 29 October 1981				SHOP / SECTION: C			
OPERATION: Welding and soldering on mild steel, aluminum, bronze, stainless steel and galvanized metals							
INTENSITY & EXPOSURE: <input type="checkbox"/> VIB <input type="checkbox"/> NOISE		HAZARDOUS MATERIAL CODE: 3		RANGE OF WORKSITE: OUTSIDE: INL <u>2</u> CIV <u>6</u>			
HAZARDS / EXPOSURE: Ozone, infrared visible light, metal and flux fumes, cadmium, lead, zinc chloride fume, zinc oxide		CONTROLS PRESENT: LEV, gloves, apron, goggles (tinted), respirator (TC-21C-202), medical monitoring		CONTROLS REQUIRED: SITE 2: LEV needs to be upgraded to provide minimum of 100 fpm capture velocity APPROXIMATE COST:			
WORKER INITIALS	LAST FOUR DIGITS	ML	OV	EXPOSURE	PROTECTED	DECONTAMINATED	SAMPLE RESULTS
B. A. D.	4509	x		lead	x	x	
T. E. B.	5802	x		lead	x	x	
O. P. L.	1719			lead	x	x	3 ppm ozone (BZ)
H. E. T.	2891			lead	x	x	
R. F. T.	2079	x		lead	x	x	0.05 mg/m ³ lead fumes (BZ)
G. T. D.	1088	x		lead	x	x	
T. C. N.	8878	x		lead	x	x	
L. E. S.	4510	x		lead	x	x	
VENTILATION: Site 1: 120 fpm avg face velocity Site 2: 50 fpm avg face velocity							

Figure 2-2b. Example of LOHHI II (Industrial Hygiene Copy)

MATERIAL SAFETY DATA SHEET				2 copies of prepared - OSHA 201 1 copy to Employer, 1 to 20-20329	
MANUFACTURER'S NAME AND FULL (Fictitious) Name of the Manufacturer XXY Paint and Varnish Company				RECORD COPY PHONE NO. 301-373-8096	
ADDRESS (Street, P.O. Box, City, State, and ZIP Code) 9 South Harvard Plaza, Irvington, Maryland 21278				NAME, TITLE AND COMPANY XX-P-404-Off White 32771	
CONTRACT NO. AND SYMBOL Contract CS-105-9888					
SECTION I		FORMULA			
REGIONS (FROM WHICH) 3010-06-579-9282		WEIGHT (LBS) 49		OUTSIDE FACE OR DIMENSIONS (INCHES) 13-3/8" x 13-3/4" x 6"	
DECEMBER 1980 NATIONAL FIRE PROTECTION ASSOCIATION SYSTEM SYMBOL					
FLAMMABILITY		HEALTH		SPECIFIC HAZARD	
PAINTS, PRESERVATIVES, AND SOLVENTS Titanium Dioxide Magnesium Silicate		% 37		THRESHOLD LIMIT VALUE (TLV) NONE METAL	
METALS Yellow Oxide				NONE	
RESIN EMULSION		20		METALLIC CORROSION	
SOLVENTS Water		42		FILLER METAL FLOW COATING OR CORE FLOW	
BIGGIE SURFACTANT Anti-foam		<1		OTHERS	
HAZARDOUS MIXTURES OF OTHER LIQUIDS, SOLIDS, OR GASES					
SECTION II - PHYSICAL DATA					
BOILING POINT (°F)		NA		SPECIFIC GRAVITY (IN @ 60°) 1.32	
VAPOR PRESSURE (PSIA)		NA		PERCENT VOLATILE BY VOLUME (%) 60	
VAPOR DENSITY (AIR = 1)		NA		EVAPORATION RATE NA	
SOLUBILITY IN WATER		Complete			
ODOR Thin off white latex paint - virtually no odor					
SECTION III - FIRE AND EXPLOSION HAZARD DATA		FLASH POINT (Approximate) NA		FLAMMABLE LIMITS NA	
		EXTINGUISHING MEDIA NA		LOWER EXPLOSIVE LIMIT NA	
		SPECIAL FIRE FIGHTING PROCEDURES None		UPPER EXPLOSIVE LIMIT NA	
		UNUSUAL FIRE AND EXPLOSION HAZARDS None			

Figure 2-3. Material Safety Data Sheet, DD Form 1813

SECTION V HEALTH HAZARD DATA	THRESHOLD LIMIT VALUES 10 ppm in air for vinyl acetate, oral LD50-940 mg/kg, rat		
	EFFECTS OF OVEREXPOSURE Formaldehyde oral LD50-800 mg/kg rat: 1-3(3-chloroallyl) 3-5-7		
	Triaza-1-azoniaadamantane chloride, oral LD50		
	EMERGENCY AND FIRST AID PROCEDURES - 1190 mg/kg, rat On contact, wash skin with plenty of water, wash eyes at once with water for at least 15 minutes. Call physician.		
SECTION VI REACTIVITY DATA	STABILITY	UNSTABLE	CONDITIONS TO AVOID
		STABLE	X Do not heat above 60° C
	INCOMPATIBILITY (oxidants, acids, etc.)		
SECTION VII SPILL OR LEAK PROCEDURES	HAZARDOUS DECOMPOSITION PRODUCTS		
	HAZARDOUS POLYMERIZATION	MAY OCCUR WILL NOT OCCUR	CONDITIONS TO AVOID
	STEPS TO BE TAKEN IN CASE MATERIAL IS RELEASED OR SPILLED Absorb on drying material. Place in waste container for disposal. Wash area with water. Do not flush into public water source.		
SECTION VIII - SPECIAL PRECAUTION INFORMATION	WASTE DISPOSAL METHOD Sanitary land fill		
	VENTILATION LOCAL EXHAUST Good natural draft MECHANICAL EXHAUST Exhaust blower to rid fumes		
	PROTECTIVE CLOVES Recommended		EYE PROTECTION Recommended
SECTION IX SPECIAL PRECAUTIONS	OTHER PROTECTIVE EQUIPMENT		
	PRECAUTIONS TO BE TAKEN IN RECEIVING AND STORING Store at room temperature. Do not freeze		
SECTION X TRANS. DATA	OTHER PRECAUTIONS Keep away from children		DOT CLASSIFICATION Non-flammable
	DOT LABEL Non-flammable	DOT MARKING Paint	EMERGENCY ACCIDENT PRECAUTIONS AND PROCEDURES
	PRECAUTIONS TO BE TAKEN IN TRANSPORTATION		

c. Health service LOHHI data maintenance. The health service copy of the inventory (fig 2-4) will identify any specific medical contraindications or indicators for assigning individuals to work with or near the hazard (i.e., persons with uncorrected dental caries may not work with white phosphorus, while someone with impaired vision may be assigned to a position where visual acuity is not required); the extent and frequency of periodic medical surveillance; protective measures to prevent or control overexposure that should be supported by the occupational health staff through counseling and teaching; and positions requiring specific health protection measures such as immunizations. In addition to the LOHHI forms, OHS will maintain the list of positions with specific stresses and/or requiring physical fitness and the persons assigned to these positions. These data shall also be recorded in the medical record of each worker involved, using the HSC Form 79 (Master Problem List) (fig E-1) or other available hazard data forms.

d. Procedures. Procedures for conducting initial and periodic surveys ~for the collection and use of LOHHI data are described in the USAEHA Technical Guide No. 022, Industrial Hygiene Evaluation Guide; DA Pamphlet 385-1, Unit Safety Management; and TB MED 501, Hearing Conservation (for noise hazards). Development and maintenance of a current, complete LOHHI require the continuing coordination of all persons concerned. Occupational health staff support of this data collection includes medical consultation regarding health hazards and referral to the industrial hygienist or safety officer of any evidence of potential problem areas (such as an increase in the number of eye injuries in a particular work area or the report of symptoms peculiar to a particular toxic substance being used). Industrial hygiene or safety questions or problems noted during the OHMD or OHN's periodic visits to work areas should be referred to the industrial hygienist or safety officer. OHS staff input to hazard identification may also include consultation with the audiologist on identification and control of noise hazards. In addition, the nurse may accompany the industrial hygienist on the onsite inspections to collect the data regarding the personnel involved while the technician performs the sampling and other industrial hygiene procedures. As stated before, supervisors and department heads also have the responsibility to keep industrial hygiene and safety personnel informed about new or changed operations and materials being used. Installation procurement officers are required to obtain Material Safety Data Sheets for every purchase of potentially hazardous materials for use at the installation (DODI 6055.5). Information regarding toxicity or other factors concerning particular substances may be obtained from USAEHA or the manufacturer of the material. In addition to the inventory of occupational hazards, an OHS list should also be developed of facilities that may present sanitation problems (restrooms, food facilities, etc.) with which the OHS may be concerned if there is no Environmental Science Officer.

LOCAL OCCUPATIONAL HEALTH HAZARD INVENTORY (LOHHI)

1. INTRODUCTION/ACTIVITY - ABD Army Depot	
2. ILS# - 704	3. DIV/SUBSTORY/OTHER - C
4. OPERATOR/UNIT/SIGNAL/UNIT/OTHER - DEAE	
5. DATE COLLECTED - 28 October 1981	6. EVALUATOR - J. Jump
7. SUPERVISOR/PCG/OWNER - E. Sizer	
8. OPERATION - Welding and soldering on mild steel, aluminum, bronzed, stainless steel, and galvanized metals	
9. HAZARDS - Gases, intense visible light, neck and face fumes, cadmium, lead, zinc chloride fume, zinc oxide	
10. CONTROLS - Local exhaust ventilation, gloves, apron, goggles (limited), respirator (TC-24C-280), medical monitoring (see narrative)	
11. NUMBER OF PEOPLE - a. Military 2 b. Civilian 0 c. Total 2	
12. STATUS OF CORRECTIVE ACTION - Recommendation to upgrade LEV was made on last survey. No action has been taken to date.	
13. REMARKS - Site 2: LEV needs to be upgraded to provide minimum of 100 fpm capture velocity.	

HSE Form 8888 (02/81) (1/82)

- b. Medical monitoring.
- (1) Preplacement and annual: eye exam, pulmonary function, urinalysis
 - (2) Preplacement and semiannual: blood lead if exposure exceeds 0.05 mg/m³
 - (3) Preplacement and biennial: chest x-ray
 - (4) Health education: cadmium, lead, ozone, intense visible light, zinc

Figure 2-4. Example of OHS Copy of LOHHI

e. Categories of OHH. Types of OHH that are to be identified fall into four categories: chemical, biological, physical, and psychological. Organic and inorganic chemical agents may be in the form of liquids, dusts, fumes, vapors, mists, or gases. Biological hazards include plant or animal agents in such forms as bacteria, viruses, fungi, insect toxins, etc. Physical hazards include such agents as radiation, heat, cold, vibration, noise, light and other physical factors such as requirements for lifting or working at high levels or on ladders. Identification of these hazards should be specific, such as what type of solvent (stoddard or tetrachloroethylene), fume (lead or cadmium) or radiation (x-ray, radioactive material, laser, microwave). Psychological hazards or stresses will include job-related conditions (shift work, repetitive motion, monotony, reduction-in-force, frequent transfers, interpersonal relationships, career development pressures, etc.) or personal factors that impair working capability either temporarily (death in the family) or over a long period of time (alcohol or other drug abuse).

2-5. Inventory of demographic and geographic factors.

a. Demographic data regarding the population to be served by the OHS provide clues as to potential health problems or needs and resources of that population. Geographic data regarding the installation itself and its location in the community provide similar clues. Responsibility for collecting and coordinating the data belongs to the OHMD or OHN. Sources of assistance in collecting the information include the civilian and military personnel offices; finance office; management information systems office (MISO); safety office; plans, operations, and training (PO&T) office; health records; and the local health department and other community health facilities.

b. Certain demographic/geographic data need to be collected and recorded only once with, perhaps, a review every 2 or 3 years to be sure no major changes have occurred. However, much of the DGF will need to be updated at least annually. Whenever possible, automatic data systems should be used to facilitate this. In any event, recording of the data should be properly organized to permit ready access and use for program evaluation and reporting.

c. Statistical population data required include the total number of civilian (AF and NAF) and military employees of the installation and of its tenants; the sex and age distribution (preferably by 5 or 10 year age-range categories); the number working on each shift; the number of General Schedule and Wage Grade employees, the number of officer and enlisted personnel, and the occupational distribution (types of work); and the geographical distribution of employees, on or off the installation. These data usually are available from the personnel offices, finance office, MISO, and/or PO&T.

d. Socioeconomic information for the population served should include the grade/rank distribution, race and ethnic factors to include the most commonly used languages and general educational levels. These data may be recorded in general terms (e.g., most employees are high school graduates; about half of workers have Spanish as their first language; etc.) and will require less frequent updating and evaluation. Other population factors to consider are those related to employees' health status. Experience data on sickness absence frequency and severity, incidence of occupational illness and injury, and prevalence of chronic disease or disability will help to identify program areas that may need emphasis. These data may be obtained from the personnel offices, MISO, safety office, and health records.

e. Geographic factors to be identified for the installation include size, location in relation to nearby communities, topography (altitude, rivers, etc.), climate, location of medical facilities both on and offpost, and installation operations located a significant distance from the OHS. Sources for these data include PO&T and local health facilities.

2-6. Inventory of resources and other influencing factors.

a. There is a variety of supportive elements and resources that may influence the effectiveness of the OHP. These need to be identified and used or considered when planning or implementing the program. Their identification is the responsibility of the OHS. Depending on the type of information, data may be gathered through consultation with responsible persons, onsite observation (one-time or over a period of time), and review of available statistical and other data. These data usually require infrequent updating and may be best recorded in brief, summary narratives.

b. The resources and other factors that can influence the effectiveness of the OHP include, but are not limited to, the following elements. The extent of command support or emphasis and of union support or interest in occupational health will influence the level of supervisor and worker cooperation. An efficient safety program and an active safety and health committee provide important complementary services. The type and extent of other health facilities on post will directly influence the scope and operation of the OHS. These range from the type of laboratory and other diagnostic facilities to support the medical surveillance program to the availability of a community health nurse with whom to coordinate health education or similar preventive medicine activities. Other influencing factors include environmental quality; the status of buildings (including the occupational health facility); availability and status of water, sewerage, and other utilities; and availability of offpost health care facilities and related resources.

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Section III. Data Evaluation

2-7. General.

a. The OHMD has the primary responsibility to review and evaluate the data collected to determine what health services are needed. Normally, this responsibility is shared with the OHN and, at installations where there is a MEDDAC/MEDCEN, with the Chief, PVNTMED. Where there is no full time OHMD, the OHN may have the primary responsibility for coordinating and evaluating the data in cooperation with the Chief, PVNTMED. The complete evaluation of the data requires coordination with other installation and MTF personnel.

b. The evaluation of data collected should identify:

(1) Those OHH that are subject to occupational health intervention (paras 2-4 and 2-8).

(2) Actions needed to eliminate the hazard or prevent or reduce the harmful impact on the worker.

(3) Other health needs of the workers related to DGF (paras 2-5 and 2-9).

(4) Actions needed to establish/improve the OHP to meet the health needs of the workers and make full use of all resources.

2-8. Potential OHH subject to occupational health intervention.

a. The list of OHH, to include positions requiring specific physical fitness standards and facilities posing potential sanitation problems, must be carefully reviewed by the OHMD, OHN, industrial hygienist, safety officer, audiologist and personnel officer. Questions to keep in mind for each OHH include:

(1) Can the hazard be eliminated or controlled?

(2) Can the impact of the hazard be reduced?

(3) What medical surveillance or other occupational health measures could be required?

b. Various engineering and medical actions may be required to prevent or control the hazard and its impact on the worker.

(1) Engineering and related controls usually include one or more of the following:

(a) Substitution of less toxic materials or a less hazardous process (fiberglass instead of asbestos for insulation, apply paint by dipping instead of spraying).

(b) Control at the source (guards on machinery, exhaust ventilation, sound Proofing, wet methods for dusty operations, and good housekeeping).

(c) Dilution (higher volume of air and/or limitations on length or frequency of exposure).

(d) Isolation or enclosure (process conducted in closed vessels, behind protective barriers, by remote control, or in a separate building).

(e) Personal protective devices (respirators, cold weather gear, hearing protectors, safety glasses, etc.).

(f) Administrative action (limit length or frequency of exposure).

(g) Proper maintenance of equipment and education regarding safe operating practices.

(2) Occupational health actions may require:

(a) Preplacement, periodic, special, and termination medical surveillance to assure initial and continuing safe worker placement (pulmonary function screening of personnel required to wear respirators, audiometric evaluation of personnel in noise-hazardous areas, complete health evaluations of firemen and guards, etc.).

(b) Health education ,specific to prevention and/or control of exposure to hazards (effect of hazard, and signs and symptoms of overexposure, specific emergency measures to take in event of overexposure, use and care of protective equipment).

(c) Provision of proper facilities and equipment for treatment of illness and injury. This may include development of procedures to follow and provision of special equipment to use when there is potential for a major disaster. such as a toxic chemical spill or leak.

(3) In many instances, more than one action is indicated. For example, noise hazardous areas will require engineering controls to reduce noise levels. When these are limited in their effect, occupational health actions will include preplacement, periodic, and termination audiograms; fitting of hearing protective devices, and worker education. In other instances, little or no action can be taken by the OHS. For example, in the case of certain toxic chemicals that cause acute, rather than cumulative, harmful effects, occupational health actions may be limited to instructions regarding proper handling of the chemical and provision of specific antidotes or emergency equipment with instructions and procedures to follow in the event of overexposure. Another example is the potential hazard of gunshot wounds on the firing range. Here, it is the responsibility of commanders and range safety officers to prevent range accidents. Occupational health personnel are not involved other than to provide guidance regarding occupational health reporting.

c. The evaluation of OHH will result in a list of hazards or positions that require occupational health intervention and a definition of what that intervention should be (e.g., five roads and grounds workers exposed to organophosphates require periodic cholinesterase determinations; 10 electricians working with high voltage lines require age-related physical stress health evaluations, annual audiograms, and instruction in cardio-pulmonary resuscitation procedures; etc.) This information should be as specific and complete as possible to facilitate identification of resources needed to accomplish the required actions.

2-9. Other health needs of workers subject to intervention within the OHP.

a. Evaluation of the demographic and geographic data and of injury/illness incidence should identify additional health needs of the military and civilian workers that require or benefit from occupational health actions. While certain of these health needs are not directly related to the job assignment, they may adversely affect the worker and his job performance. Actions that can prevent or control such adverse affects are within the purview of the OHP.

(1) The number and location of installation personnel, their occupational distribution, and the work shifts will suggest the size and location of the occupational health service and its staff. If a significant number of employees work on the second shift and are in hazardous activities, it may be necessary to assign an OHN or medical technician to cover the OHS for that shift. In other instances, the MTF emergency room may provide adequate coverage for the 2nd and 3rd shifts. Branch occupational health facilities may be needed if there is a large group working with particular potentially hazardous materials and who are located some distance from the main OHS. In addition, some employees with specific occupational health requirements may have permanent work assignments at locations away from the installation. It will be the OHMD's or OHN's responsibility to insure that these employees are provided the necessary occupational health services and to monitor them periodically as indicated.

(2) The age range, sex distribution, sickness absence incidence, and prevalence of chronic disease will indicate types of health problems that may occur or merit specific preventive, educational, or treatment measures. For example, a workforce of young women may need health education and counseling related to nutrition, personal hygiene, and gynecological problems. In contrast, a middle-age to older group of men may benefit from selected disease screening programs with referral and counseling for medical problems, or assistance with planning for retirement. Many workers, military and civilian, have chronic diseases or disabilities that may affect or be affected by their work assignment. Identification of these employees, coordinated with selective placement, counseling, and referral services is essential to maintenance of the individual's optimum health and to avoid aggravation of the condition by the work assignment.

(3) Occupational illness and injury incidence data may point out requirements for coordination with safety and supervisors regarding use of protective equipment, safe work practices, and related control measures. They may also identify requirements for special health service supplies, such as whirlpool or other physiotherapy equipment or first aid kits for specific hazards or locations.

b. The evaluation of DGF and other health problems should produce a list of additional health needs of workers and the occupational health actions that should be taken to meet those needs. For example:

<u>Health Problem</u>	<u>Action</u>
Large number overweight employees	Provide obesity education and counseling, or develop a weight reduction program.
30 percent of workers have Spanish as their primary language	Develop or obtain OH orientation and health education materials written in Spanish, and make arrangements for an OH staff person to serve as Spanish interpreter, when needed.

2-10. Other factors to support the OHP. Although there are numerous other factors that could be beneficial in establishing or improving the OHP, the evaluation will show which actually will be beneficial and which may be of little or no assistance or support. For example, a community health nurse may be assigned to the installation, but because of various other urgent priorities, she has little time to work with the OHN in the health education program. On the other hand, an adult health nurse practitioner may be available and interested in coordinating with the OHS to develop a long term plan for disease detection, referral, and followup. The evaluation of these factors should provide a list of available support sources and the type of support they can be expected to provide. For example:

<u>Factor</u>	<u>Support</u>
Chief PVNTMED is Medical Officer with preventive medicine preparation	Medical direction and support for program
CPO has comprehensive ADP system for personnel records	Scheduling of job related medical surveillance
Installation Public Information Officer	Publication of health education articles and OHS publicity
Local unit American Heart Association	Health education campaign, hypertension screening program
MEDDAC (or Community) Inhalation Therapy Unit	Lung function screening (tests, interpretation of results, teaching of techniques)
Local union with demonstrated interest in safety and health	Assistance with and publicity for promotion of use of protective equipment and participation in health evaluation programs

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Section IV. Occupational Health Program Plan

2-11. Definition. The OHP plan is an overall design developed to facilitate implementation of the program.

a. The plan is based on:

- (1) Overall objectives of the Army OHP (para 1-7).
- (2) Legal and regulatory requirements (para 1-6).
- (3) Specific needs of the installation as identified in the data evaluation (chap 2, sec III).
- (4) Available/obtainable resources.
- (5) Sound management and medical principles.

b. The plan is the primary responsibility of the OHMD and/or the OHN program coordinator, but its development requires close coordination with all other personnel with significant responsibility for implementation or support of the OHP. The plan must include:

- (1) Definition of priorities for the needed or desired OHS required by law and regulation and/or those identified in the data evaluation.
- (2) Specific measurable objectives for each program element (paras 2-13 and 4-4c. and app F and G).
- (3) Methods and resources to be used to achieve the stated objectives.
- (4) Measures to be used to evaluate the achievement of stated objectives.

2-12. Setting OHP priorities.

a. General. To assure that legal and regulatory requirements as well as primary health needs are met, and optimum use is made of available resources, priorities shall be established. This applies whether an overall OHP is being initiated or whether a new aspect of an ongoing program is planned. The elements of the OHP that are mandated by law or regulation must be met first. Other elements that are not mandated will be assigned a lower priority and ranked according to the impact the unmet health need might have on the workplace and its productivity. The following lists present, in broad terms, those OHP elements that are either required (1) and (2) below or considered desirable [(3) below] for both military and civilian employees.

- (1) Program elements required by law and regulation.*
 - (a) Inventory of OHH and listing of positions requiring physical fitness.
 - (b) Job-Related Medical Surveillance
 - Preplacement/preassignment
 - Periodic
 - Termination
 - (c) Treatment of occupational illness and injury.
 - (d) Employee education regarding job hazards.
 - (e) Safety and health inspections.
 - (f) Medical records.
 - (g) OSHA records/reports.
 - (h) Medical directives.
 - (i) Alcohol and Drug Abuse Prevention and Control Program.
- (2) Program elements required by regulations.
 - (a) Industrial hygiene surveys.
 - (b) Administrative examinations.
 - Fitness for duty
 - Return after illness
 - Disability retirement
 - (c) Elective periodic vision screening.
 - (d) Emergency/palliative treatment of nonoccupational illness/injury.
 - (e) Sickness absence prevention.
 - (f) Chronic disease surveillance.

* Respiratory protection, radiation protection, and hearing conservation programs are sub-elements of the OHP specifically required by law.

- (g) Pregnancy surveillance.
- (h) Job-related immunizations.
- (i) Epidemiological investigations.
- (j) Nonjob-related health education/counseling.
- (k) Semiannual occupational health report.
- (l) Local regulations/supplements (OH).
- (m) Standing operating procedures (OHS).
- (3) Elective program elements.
 - (a) Voluntary health maintenance evaluations.
 - Medical examinations
 - Nursing health appraisals
 - Specific disease screening
 - (b) Nonjob-related immunizations.

b. Specific priorities. Even within the broad priorities cited above, it is necessary to set more specific priorities. For example, it is not possible to develop a comprehensive inventory of hazards all at once. Therefore, those areas which have the most or the worst potential hazards should be given first priority for the identification of hazards. The same policy applies in setting up the schedule for job-related medical surveillance. Those employees who are exposed to the more critical hazards (i.e. carcinogens, heavy metals, or chlorinated hydrocarbons, etc.) should be scheduled first. In the area of administrative functions, development of an installation occupational health regulation, or supplement to AR 40-5, has a high priority since it forms the basis for the OHP.

2-13. Occupational health program objectives. Specific objectives must be developed for the installation OHP that are consistent with the Army's general occupational health objectives and the MEDDAC/MEDCEN program objectives. The program objectives should be statements of the desired end results to be achieved by the program within a given time period. Objectives should be realistic, measurable, and precisely stated. They should specify how much of what, affecting whom, is expected to happen, by when. The stated OHP priorities and objectives are an integral part of the OHS operating program document (para 4-4c). More specific guidelines for writing objectives are given in appendix F, and an example is shown in appendix G.

2-14. Methods and resources to achieve objectives.

a. The methods used to achieve the objectives must be defined in the OHP plan. Delineation of the specific activities that are to be undertaken should include what is to be done, by whom, when (including frequency), and where. Determination of the best alternative method depends on the available resources (money, materials, manpower and skills, facilities, time, etc.), most of which should have been identified in the inventory of resources. Exploration and analysis of these resources in relation to the stated objective to be accomplished will identify the alternative approaches from which to select the most feasible, efficient, and effective method to be used. This includes the identification and avoidance of unnecessary duplication of resources and services. In addition to medical costs, the cost of work time lost by the employee in obtaining occupational health services must be considered when selecting the best method for providing any service

b. Various categories of resources required (e.g., MEDCEN/MEDDAC, installation, and community resources) are listed below. Other DA resources (HSC, USAEHA, etc.) are discussed in appendix D. More definitive discussions regarding resource use are given throughout chapters 3 and 4.

(1) Occupational health staff: medical, nursing, technical, and clerical. This includes the number of each type staff personnel needed, the level of their preparation (including special skills, such as audiometry, spirometry, etc.), and resources for their initial orientation and continuing education. Staffing should also take into consideration MEDCEN/MEDDAC patient treatment and examination resources (emergency room, physical examination section, TMC's, laboratory and x-ray, etc.). For example, the flight surgeon has responsibility for and provides the various OH related services for flight personnel (clinical care, medical examinations, medical advice and assistance, accident investigation).

(2) Occupational health service facilities: health care facilities (waiting areas; treatment, examination, counseling, and patient holding rooms; laboratory and x-ray; easy access by ambulance; conference room; etc.) and administrative areas (staff offices, records area, library, storage area, etc.).

(3) Occupational health equipment and supplies, both expendable and nonexpendable: clinical (patient examination and disease screening, treatment, etc.), environmental (usually this relates more to PVNTMED and industrial hygiene activities, but the OHS may require such equipment as sound level meters, etc.), and administrative (files and other clerical items).

(4) OHS reference library: administrative (copies or excerpts of all pertinent laws, regulations, and policies) and professional (texts, journals, guides, etc.) (app A).

(5) Automatic data processing capabilities.

(6) Consultant services: MEDCEN/MEDDAC medical, nursing, optometry, audiology. environmental health, administration, and other specialists; USAEHA; and community medical and related specialists, including local and state occupational health and safety consultants and educators.

(7) OHS patient referral resources: MEDCEN/MEDDAC, other Federal facilities, and community health care agencies and/or individuals, to include rehabilitation and vocational training services and voluntary or official health agencies.

(8) Other installation resources:

(a) Personnel with specific assignments or talents pertinent to operation of the OHS (e.g., civilian and military personnel offices, public information officer, safety officer, first aiders, first aid instructors, firemen, volunteers, etc.).

(b) Key personnel of major activities or tenants at the installation (e.g., Division surgeons, tenant safety and personnel officers. etc.).

(9) Other community resources: civil or social groups with a concern for health, colleges and vocational schools, etc. (para 4-8d).

c. So far as possible, current data should be maintained concerning installation and community resources that will be used to complement or supplement the OHS capabilities. These data include the resource, its location, key or contact personnel, the services it can provide, duty hours, and, when indicated, specific instructions regarding use of the resource.

2-15. Planning for program evaluation. Plans for evaluating achievement of objectives must be included in the OHP plan. Evaluation plans will define the scope or type of evaluation to be done, what will be evaluated, and the methods and criteria to be used to document and assess the level of achievement. Effectiveness and efficiency must be considered, as well as the degree of accomplishment, in measuring attainment of objectives. The plan should provide for ongoing and/or interim status or progress reviews in addition to annual or final evaluations. The evaluation plan should also keep in mind how the evaluation results will be used to set priorities, define needed program changes, support budget or manpower requests, etc. Section III, chapter 3, discusses OHP evaluation in more detail.

CHAPTER 3

OCCUPATIONAL HEALTH PROGRAM IMPLEMENTATION AND EVALUATION

Section I. Introduction

3-1. General.

a. Implementation of the OHP is based on the installation occupational health plan (sec IV, chap 2). In developing the OHP, it must be reemphasized that each installation program will be different. Certain elements will be common to all, while other elements may be unique to certain types of installations. Few programs, if any, will contain all the elements of an ideal OHP. However, all shall contain those elements required by law or regulation (para 2-12). Methods for implementing the program will also vary, depending upon the type of occupational health service organization (para 4-2) and available resources. As with the OHP plan, program implementation is the responsibility of the OHMD or the OHN program manager/coordinator, to include necessary coordination with and use of MTF and other resources supportive to the OHP.

b. The success of any aspect of the OHP is directly related to the thought and care invested in planning and initiating the program, as well as to the professional quality of implementation. This includes involvement of all concerned, including employee groups, as pertinent during the progressive steps of program development. To promote acceptance and utilization of a program, it is important to solicit employee concerns, views, and ideas in the planning stages; to seek their cooperation in publicity and promotional activities; and to get their reactions to the effectiveness of the program. This also includes coordinating with other MTF or installation resources with potential input to a program; meeting with supervisors and employee groups to explain a program, answer questions, and encourage participation; and/or providing items in post publications, program announcement posters, and other publicity actions.

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Section II. Occupational Health Program Implementation

3-2. Inventory of occupational health hazards. The LOHHI and the list of positions with specific physical fitness requirements is a basic element of the OHP. Paragraph 2-4 identifies the recommended content of the inventory and discusses its development and maintenance, which require coordinated, ongoing effort.

a. Responsibility. Primary responsibility for medical aspects of the inventory rests with the OHMD. This begins with physician's review of the LOHHI as it is developed and/or updated to identify: medical contraindications for job placement; those hazards or positions requiring placement, periodic, or termination medical surveillance; and the extent and frequency of such surveillance. Refer to paragraph 3-3b(1) for the recommended references to follow in developing the medical aspects of the hazards inventory. In order for the physician to meet his responsibility, a copy of the inventory must be available in the OHS and it must be kept current. In addition, the responsible physician and the nursing staff will schedule regular, periodic visits to the work areas (industrial and non-industrial) so as to be more fully informed about the work situation and operations. These visits also provide an opportunity to establish working relationships with supervisors and employees and to provide onsite health education and counseling relative to potential job hazards, use and care of protective equipment, and other health concerns. In addition to the regular visits, worksite visits may be required when problems arise. Such visits are essential to epidemiological investigations and prevention of recurrence of the problems, as well as to indicate or verify medical surveillance requirements.

b. Format. The format in which the occupational health copy of the inventory of hazards is maintained will depend upon available resources. Cross indexed card files or copies of the LOHHI forms (para 2-4b) filed in loose leaf notebooks allow for flexibility and data retrieval. Figure 3-1 offers three examples of card file systems that tie the inventory of hazards into the corresponding job-related medical surveillance program. Development of local forms required by such systems must be coordinated with the MTF forms control officer. As ADP facilities become available, the inventory and the schedule of required medical surveillance should be computerized. This permits much greater flexibility, easier updating of data, and better data retrieval.

MEDICAL SURVEILLANCE CARD				
INSTALLATION	REG #	UNIT	SECTION	WARRANTY #
ABD Army Depot		FORSCOM		
SUPPLY NAME	FILE #	UNIT SAFETY OFFICER		
J. Noit	9909	S. Doeye		
DESCRIPTION OF OPERATION Construction equipment repair				
HAZARD	MEDICAL SURVEILLANCE	FREQUENCY	PROTECTIVE EQUIPMENT	PERSONNEL
Noise	Audiogram	Annual	ear plugs	J. Hart,
Welding	PFT	Annual	respirator	S. Rail,
Fumes	Chest x-ray	Biennial	respirator	M. Jones,
		Annual	EXPOSURE	J. Roof,
UV, IR, R	Eye exam	Annual		T. Noit,
Lead (if exceeds 0.05 mg/m ³)	Blood lead	semi-ann	respirator	P. Stark
	CBC, UA	Annual		

OCCUPATIONAL HEALTH CARD		
Name	Birth date	Work area
J. Hart	29 Aug 28	welding
Job title	Serial no.	NUMCAP CODE
Welder	9909	
Occupational hazards to which individual is exposed Noise, UV, IR, IV, lead (less than 0.05 mg/m ³) welding fumes		
Major chronic conditions, allergies, other pertinent medical information None		
Examinations required	Interval	
Audiogram, eye exam	Annual	
PFT	Annual	
Chest x-ray	Biennial	
Px, CBC, UA, BUN, Creatinine	Annual	

OCCUPATIONAL HEALTH CARD				
NAME	LAST	FIRST	MI.	DOB
Hart, J. (NMII)				000 00 0000 29 Aug 28
CJOB	Serial no.	Frequency of exam: annual		
Welding	9909			
OCCUPATION HAZARD/EXPOSURE		MISCELLANEOUS INFORMATION		
1 Noise 2 UV, IR, IV 3 Lead (less than 0.05 mg/m ³) Welding fumes Examinations required: 1 Audiogram 2 PFT 4 Chest x-ray (biennial) 5 Px 3 CBC, UA, BUN, Creatinine Eye Exam		Review instructions on use and maintenance of ear plugs, respirator		

EXAMPLE

Figure 3-1. Examples of card file systems coordinating hazard data with medical surveillance requirements

3-3. Employee health evaluation.

a. Common factors .

(1) The health evaluation program is a key part of the OHP. It provides initial and continuing data relative to the workers' health status. This is basic to safe worker placement and to the planning and provision of individual health care and other health service programs.

(2) There are two general classifications of health evaluation examinations provided by an occupational health service. First are the preplacement and periodic job-related examinations required to assure initial and continuing safe job placement of the worker, both for himself and for his coworkers. Included in this group are the preassignment and periodic age-related medical examinations for military personnel (AR 40-501). As noted earlier, the job-related health evaluations are an essential part of the program and are considered to be in Priority 1 for medical care as defined in AR 40-3. Closely allied to the required job-related preplacement examinations are the recommended baseline health evaluations of newly hired employees who are not required to have preplacement examinations [para d(2) and (4) below]. The second class of examinations are the voluntary evaluations (medical examinations, nursing health appraisals, or specific disease screening programs) offered to promote the general health of all workers. The elective health evaluations are provided only after other priorities have been met and when resources are available, either from the installation or the community.

(3) The health examination program offers an excellent means for establishing effective working relationships with installation personnel. Because the health examination may be an extended procedure, the worker has an opportunity to observe and react to the apparent attitude of the health service personnel and to their treatment of him and others. In addition, supervisors' cooperation or resistance will be influenced by the consideration they believe is given to their manpower needs when health examinations are scheduled and when the results affect the worker's job assignment. To foster worker cooperation, as well as to allay worker anxieties about the procedure, assurance should be made that the worker is received with respect and courtesy, is informed about and understands the purpose and content of the examination, is properly instructed regarding special procedures, is processed as promptly as possible through the examination, and is counseled and assisted as indicated regarding findings, referrals, and follow-up actions.

(4) Efficient administration of the health evaluation program requires close coordination between the OHS, CPO, MILPO, supervisors, and other MTF and installation personnel (i.e., MISO) concerned.

(a) Designation of a specific day, or days, and time when preplacement examinations will be performed will facilitate work load planning by both the CPO and OHS/MTF staffs. However, variable demands for new employees and related examinations will require flexibility and close communications about changes in CPO requirements and health service capabilities.

(b) The scheduling of periodic health examinations (job-related or elective) must insure appropriate and timely accomplishment of the health examinations commensurate with the capabilities of the OHS and/or MTF without creating production problems for supervisors. Standing operating procedures relative to scheduling will clearly identify the functions of all concerned (health service staff, CPO, MILPO, supervisor, central appointment service, physical examination section, etc.). Actual scheduling procedures will depend on the installation's needs and facilities. Where available, a computerized system offers the most efficient means for maintaining the list of employees (civilian and military) requiring job-related medical surveillance (or age-related voluntary health evaluations, if offered). Such systems may be programmed to identify the personnel requiring examinations, their job title or MOS and/or hazards and work location, the due date and/or date of last examination, and the type or extent of examination to be performed. The personnel officers and health service staff can then use these printouts to schedule the examinations. When ADP systems are used for scheduling, the OHS staff must define clearly what data are needed and how they will be used. Preliminary inquiries will identify data already in the system and how they are used. For example, CPO or Finance ADP programs may identify civilians by name, social security number (SSN), job title, work location or cost codes, and birth month. Similarly, MILPO programs will identify military by name, SSN, duty MOS and birth month. These provide a base on which the OHS program can be developed by adding such elements as hazards and surveillance codes. When ADP systems are not available, health examination scheduling is usually handled by DF between the health service and department chiefs or supervisor based on tickler card files (fig 3-1) or other manual systems. At some installations the MEDDAC central appointment service makes all appointments for examinations in coordination with the OHS.

(c) Processing of periodic examinations at those installations (e.g., FORSCOM, TRADOC installations) where several MTF activities may be used to conduct the examination requires careful coordination to assure the medical surveillance is specific to the job and its hazards. Preferably, the workers (civilian and military) will be routed through the OHS where the interim health/work history is taken and specific evaluation procedures (laboratory tests, pulmonary function screening, etc.) ordered, whether or not the examination is performed in the OHS unit. The results of the examination should also be routed through the OHS for review (usually by the OHN) prior to filing. When workers and examination results cannot be routed through the OHS, the personnel providing the examinations should be oriented to work environment, exposures, and other factors that must be considered when performing job related medical surveillance. If the review of examination results indicates possible overexposure or other potential problems, the OHN should refer this to the OHMD and/or request verifying laboratory work, as well as counsel the worker regarding safe practices, use of personal protective equipment, etc. When indicated, epidemiological investigations (app H) should be initiated in coordination with preventive medicine, industrial hygiene, safety, and other personnel as indicated.

(d) Where special preparatory instructions for examinations/tests are required, these should be forwarded to the worker through the supervisor.

(e) When workers do not keep job-related examination appointments, this should be documented on the medical record and written notice of the missed appointment should be forwarded through CPO and department channels to the supervisor. It is then the supervisor's responsibility to see that the individual reports to the OHS for the examination.

b. OHS responsibilities.

(1) The OHMD is responsible for determining what examinations will be given; their extent and frequency; for whom and by whom; medical recommendations relative to the worker's job assignment; and the interpretation of examination results, counseling, referral, and related follow-up. The physician's determination of the type, scope, and frequency of examinations will be based on his review of the inventory of hazards, observations and knowledge of work operations, legal requirements, and accepted medical practices. The following documents will be used, by all AMEDD elements providing occupational health services, as the basis for designing periodic job-related medical surveillance programs:

(a) DOD Manual 6055.5-M

(b) DHHS (NIOSH) Publication No. 81-123, Occupational Health Guidelines for Chemical Hazards.

(c) Appendixes E, G, and H of the USAEHA Technical Guide No. 001 (and later versions of these documents as they are revised and disseminated)

(d) TB MEDs 279, 501, 502, 506, and 523

(e) TB MEDs, DA Pamphlets and other documents concerning periodic job-related medical surveillance requirements as they are developed and formally promulgated.

When these determinations have been made, the OHMD may or may not actually administer medical aspects of the examination, depending on whether or not he is assigned full time to occupational health. When the OHMD is not directly involved in the performance of the examination, he shall define the parameters to be used by others (usually the OHN) in deciding when he should be consulted about any aspect of the health evaluation. He will also provide the medical liaison with other physicians (Federal or private) regarding scope or interpretation of job-related examinations. This includes providing consultation and guidance on occupational health aspects of medical examinations that are the responsibility of division or flight surgeons.

(2) OHN responsibilities in health evaluation will vary with the extent of OHMD support; the availability of ancillary personnel and other MEDDAC support facilities; qualifications and/or credentialing (AR 40-66) of the OHN to perform such procedures as physical assessment of body systems, audiometry, or tests; whether or not the OHN is functioning in a clinic situation or as a program coordinator with no separate OH clinic; etc. When indicated, written protocols or directives (para 4-11b), signed by the responsible physician, shall be prepared to clearly define the scope and responsibilities of the OHN (based on her qualifications) for coordination and implementation of the medical surveillance program. Nursing functions may include the following. (Note: Those activities marked with an asterisk are common to all situations and would apply to essentially every OHN.)

*(a) Coordinate with the OHMD, personnel officer, ADP (when appropriate) and supporting MTF facilities (laboratory, x-ray, physical examinations section, etc.) to establish the health examination schedule and to be sure that all are informed about the requirements for the program.

*(b) Advise the worker regarding the purpose and scope of the examination, and provide appropriate instructions.

*(c) Conduct and record the health and work history (app I).

*(d) Identify the requirements for special tests, assure they are performed IAW protocols developed by the OHMD, and the results are recorded for civilian and military employees receiving job-related medical surveillance.

(e) Perform or assure/supervise the performance of required screening tests such as vital signs; height and weight measurements; and vision, hearing, and pulmonary function screening. In some instances the OHN may perform some clinical laboratory tests or collect samples for them.

(f) When qualified and credentialed, perform the physical assessment of the body systems.

*(g) Review the health evaluation data, compare these with findings of previous examinations, and alert the examining physician to any abnormal findings or significant information noted during the health/work history or preliminary screening procedures.

*(h) Provide the worker with health education or counseling concerning job-related health hazards; use and care of protective equipment; and personal health care/maintenance regarding any obvious problems such as obesity, smoking, or personal hygiene.

(i) Counsel workers, IAW the physicians findings and instructions, on completion of physical examinations; be sure they understand the findings and actions they should take to correct or control health problems; and provide necessary information on available resources and their use.

(j) Interpret to personnel officers, supervisors, and safety personnel the physical capabilities and/or limitations of the worker in regard to job assignment.

*(k) Assure proper maintenance and use of health records and files to include preparation of statistical and narrative reports; epidemiological followup and/or studies; and program evaluation related to cost-effectiveness, appropriateness of scope of examinations in relation to requirements or exposures, etc.

(1) Instruct and supervise clerical and ancillary staff as to their health examination functions.

(3) Clerical and ancillary OHS staff responsibilities should be commensurate with their level of skill and knowledge. Examples of functions that may be delegated to them include:

(a) Maintain the OHS hazard inventory and medical surveillance roster or schedule.

(b) Arrange appointments for examinations including follow-up communication on "missed" appointments.

(c) Perform health histories and screening tests IAW their qualifications, training, and OHN direction/supervision.

(d) Maintain statistical records and assist with preparation of reports.

c. Other MTF responsibilities. functions and responsibilities of other MTF units will vary with the type of installation (DARCOM versus other MACOM), and whether or not the OHS is a clinic with the capability for performing the examinations. When the OHS lacks the capability for any^ clinical aspect of the job-related medical surveillance program, the supporting MEDDAC/MEDCEN should be so informed and action to obtain the necessary services will be coordinated with the MEDDAC/MEDCEN.

(1) Usually at installations where the only MTF supporting the OHP is an US Army Health Clinic (DARCOM, DLA, Corps of Engineers), the USAHC has full capability for performing the examination. The exceptions may be when special laboratory or other tests are required. Generally, such laboratory work is referred to the supporting MEDDAC or MEDCEN. Radiology and other special test support may be provided by the MEDDAC/MEDCEN or under contract by community health care facilities.

(2) Where the OHS is colocated with a MEDDAC/MEDCEN and the OHS is a clinic with at least part-time onsite OHMD support, other MTF activities may be responsible for:

(a) Laboratory and x-ray support

(b) Audiology support to include performance and interpretation of audiograms for military and/or civilian employees.

(c) Optometry support to include assistance with the vision screening program and eye refractions for personnel required to wear industrial prescription safety glasses if the employee has not previously worn glasses or it has been administratively determined that the present prescription glasses are inadequate.

(d) Medical examinations of military personnel.

(e) Scheduling of examinations through the Central Appointment Service.

(3) When the OHS has no clinic capability and limited occupational physician support, MTF responsibilities will include all of the above plus the medical examination of civilian, as well as military, employees. In such instances, these examinations generally are performed by the Physical Examination Section.

(4) Where there is a flight surgeon's office all flight related health evaluations are usually performed at that facility.

(5) In some instances military personnel may receive their medical surveillance at the Troop Medical Clinic.

d. Preplacement examinations.

(1) The purpose of the preplacement physical examination (which is performed prior to job assignment) is to determine physical capabilities and health status of the individual to assure safe/healthful placement of the worker. The examination also provides baseline data useful in developing health maintenance and health care programs related to occupational health.

(2) Office of Personnel Management policy limits mandatory preappointment medical examinations to applicants for positions with specific physical requirements or potentially hazardous duty exposures or when determined necessary by the employing agency/installation. FPM Supplement 339-31 defines these limitations in more detail. Local application of this policy to determine which installation positions require partial or complete preappointment health evaluation is the responsibility of the personnel officer. He should coordinate this with the OHMD and safety to assure that all such positions are included. The limitation on mandatory preappointment examinations does not preclude provision of after-hire health evaluations for occupational health purposes of new employees who did not receive preappointment examinations (FPM Letter 339-10).

(3) SF 78 (Certificate of Medical Examination) (fig E-2), usually in conjunction with SF 93 (Report of Medical History) (fig E-3), is completed on all AF applicants required to have a preplacement examination. [DA Form 3437 (Certificate of Medical Examination) (fig E-4) is completed for NAF applicants.] The examination is conducted at the MTF, but it may be performed at another Federal MTF or by the individual's personal physician at the applicant's expense. Regardless of where the examination is performed, the medical portion of SF 78, parts A, 3, and C will be included in the individual medical record and parts D, E, and F will be maintained by CPO in the official personnel folder. For examinations performed at another location, the findings will be reviewed by the OHMD or OHN to be sure all required aspects of the examinations have been performed. For example, many local physicians do not have the equipment to perform audiograms or pulmonary function screening. If such baseline evaluations are required because of potential exposures of the job assignment, the OHS will arrange to provide these tests and record the results in the health record. Also, care should be taken to obtain and record as complete a health/work history as possible (app I). When required by the proposed work assignment or history, special baseline tests specific to the potential hazard involved (liver function, blood lead, etc.) will be performed in addition to the evaluation parameters contained in SF 78. Where only limited evaluation is indicated (e.g., audiogram for work in noise-hazardous area, vision screening for work areas with specific vision requirements or potential eye hazards), the preplacement examination will be restricted to those parameters related to the potential work assignment. Military personnel being assigned to positions with potential occupational health hazards will be given the specific tests indicated if these have not been included in their preassignment or other health examinations.

(4) Applicants for positions not requiring preplacement examinations complete SF 177 (Statement of Physical Ability for Light Duty Work) or DA Form 3666 (Statement of Physical Ability for Light Duty Work) for NAF employees (figs E-5 and E-6). This is reviewed by the personnel interviewer who may request further health evaluation by the OHS if there are questions regarding the applicants health status. Although SF 177 is a personnel form (not medical), it is useful to have a copy of the form forwarded to the OHS after the individual is hired for inclusion in the medical record. In addition, all light duty employees should be scheduled for a baseline health evaluation (history, blood pressure, vision and hearing screening) as soon as possible after hire. This baseline evaluation is an important OH program activity. It identifies personnel with known or unknown health problems needing referral and/or followup and provides reference data for planning health care. This may be accomplished during the employees new-hire inprocessing, or an appointment can be set up at that time or when the OHS is sent the periodic list of civilian accessions, transfers, and losses. The results of this screening are recorded on SF 600 (Chronological Record of Medical Care) (fig E-7), DD Form 2215 (Reference Audiogram)(TB MED 501), and the vision test card (fig E-8).

(5) All new employees should inprocess through the occupational health clinic to assure all necessary baseline health evaluations have been done and to orient the worker to the OHS, its purpose and services, and how and when to use it.

e. Periodic job-related medical surveilliance .

(1) The purpose of periodic job-related health evaluation is to assure continued safe, healthful job assignment and to detect early evidence of any adverse effect of the work upon the worker's health; Job-related medical surveilliance is required by regulation and sound occupational medical practice. In addition, for certain workers, examinations are mandated by law (asbestos workers) or specific OPM regulations (mobile equipment operators). Termination evaluations are required by certain work assignment/exposures, such as workers potentially exposed to noise, radiation, asbestos, etc. These individuals will be identified and referred for health evaluation prior to terminating their assignment at the installation

(2) It is the responsibility of the MTF to provide the examinations either through its own resources, or other available facilities (Federal or community) when the MTF lacks the necessary capability. If an employee refuses to have the job-related health evaluation conducted at the MTF (and the MTF has the essential capability), the employee may elect to have the evaluation performed by his personal physician. In this event, the employee is responsible for the costs of the examination and the OHS must assure that the examining physician is fully informed about the employee's potential job hazards or physical requirements and the recommended content of the examination. The results of the examination are returned to the OHS for any necessary action and filing in the medical record. If the employee refuses to have any required job-related examination, he must be informed of the potential risk incurred by this refusal to be examined and he should be requested to sign a statement that he understands this risk but does not wish to be examined. This will be documented in the medical record. In addition, failure of an employee to comply with an administrative regulation (e.g., one that requires job-related examinations) may make the employee subject to disciplinary action.*

* Letter, DAPE-CPP, Office of the Deputy Chief of Staff for Personnel, 31 January 1978, subject: Inclusion of Requirements for Audiometric Tests in Position Descriptions, New Cumberland Army Depot.

(3) The frequency and scope of job-related medical surveillance examinations must be directly related to the type of potential occupational health hazard or to the physical stress or fitness standards of the job. This includes periodic and termination health evaluations. The evaluation consists of a health/work history and health assessment that may range from a single blood test or an audiogram to a comprehensive medical examination of all the body systems. For individuals required to have age-related physical examinations, including military personnel, the health/work histories will be evaluated to be sure all essential elements of the examinations are identified and provided. Where indicated, tests required more frequently than on an annual or age-related basis (such as for personnel working with lead) will be scheduled as appropriate. (Close coordination between the OHS, supervisors, and physical examination section is essential to accomplish such military job-related medical surveillance.) Conversely, any unnecessary examinations shall be avoided. For example, routine mobile equipment operators having no hazardous work exposures or health problems may need only to complete SF 47, Physical Fitness Inquiry for Motor Vehicle Operators, usually administered by the driver's license section of the motor pool, and have periodic vision and hearing screening tests. Only if the SF 47 response indicates a potential problem will further health evaluation be required. An exception to limiting the health evaluation to the body systems at risk may be made when local laboratory procedures make it necessary and more economical to do a battery of tests instead of one or two specific tests.

(4) The interim health/work history will include a careful review of all potential occupational health hazards the individual may have encountered (including any resulting from hobbies or other personal activities) and any subjective evidence of possible overexposures (app I). Such information will indicate whether further specific health evaluation tests may be required in addition to the usual evaluation procedures defined by the OHMD for the worker's regular work assignment.

(5) The SF 78, with or without SF 93, (SF 88 and SF 93 for military) may also be used to record the findings of the periodic medical surveillance when a complete physical examination is required. It is supplemented by the laboratory, vision, hearing, and any other required test reports. When a complete examination is not required, the SF 600 may be used with supplemental test report forms to record the history and findings of the examination. Care should be taken to record all pertinent history and other findings, as well as recommendations resulting from the evaluation.

f. Specific job hazard surveillance programs. Although a part of the overall job-related medical surveillance program, there are several areas for which definitive programs have been developed. These include the following:

(1) Hearing conservation. The hearing conservation program is described in detail in TB MED 501. While the Army Medical Department is much concerned with protecting the hearing of personnel exposed to munitions/ combat weapons noise, the primary concern of the occupational health staff is for the military or civilian person in the noncombat work situation. The goal is to prevent or control exposure to hazardous noise in the work environment and so to conserve the hearing acuity of the persons involved. Where audiologists are assigned, they have the primary responsibility for the program as program directors. The audiologist will coordinate with the occupational health and safety personnel to be sure their functions are clearly defined and all aspects of the program for military and civilian personnel are accomplished and properly reported. Where there is no audiologist, the OHS will have major responsibility for implementing the program. The local supplement to AR 40-5 should define responsibilities of all personnel concerned (installation and MTF). Depending on the situation, OHS functions may include:

(a) Maintain the roster of noise-hazardous jobs or areas (DD Form 2214, Noise Survey). (Primary responsibility for the roster usually belongs to industrial hygiene or the audiologist, but the OHS should at least have a copy) .

(b) Initial, periodic, and termination audiometric examination of personnel assigned to noise-hazardous areas [DD Forms 2215 and 2216 (Hearing Conservation Data)].

(c) Fit preformed earplugs and provide health education programs in relation to the hazardous effects of noise, prevention of hearing loss, and use and maintenance of personal protective equipment.

(d) On all other (nonexposed) personnel perform initial audiometric evaluations and offer periodic evaluations as feasible within the capabilities of the health service staff.

(e) Provide or request review and interpretation by a physician or an audiologist of audiograms that indicate a requirement for additional testing and consultation. Refer personnel for such follow up when indicated.

(f) Maintain proper records, including audiograms, and prepare pertinent statistical and narrative reports for the hearing conservation program. Reports should include explanations about the cause and disposition of any progressive hearing losses noted.

(g) Assure that all health service staff performing audiograms have documentary evidence that they are certified audiometric technicians through approved training in the procedure; provide for periodic refresher training when indicated.

(h) Check the calibration of the audiometer (DD Form 2217, Biological Audiometer Calibration Check) and be sure that audiograms are performed in an approved sound attenuated booth or room.

(2) Vision conservation. The occupational vision program is defined in AR 40-5 and TB MED 506. The program has two major goals: to assure the employee's vision meets the vision criteria of the job, and to protect the employee's vision from any adverse effects from his job. The Safety Office is responsible for identifying and posting eye-hazardous jobs or areas. The OHS and/or the Optometry Service is responsible for initial and periodic vision screening of all potentially exposed personnel. Protective eyewear is supplied through the Optometry Service, OHS, Safety Office, or supervisors (nonprescription eyewear). When prescription industrial safety glasses are required and it has been determined that the present prescription is inadequate or the individual has not previously worn glasses, the eye examination for military and civilian employees is provided by the MTF either from the Optometry Service or from local eye practitioners at Government expense (para 4-21a(2), AR 40-3). OHS activities in the vision program may include:

(a) Maintenance of the OHS list of eye-hazardous positions and of positions with specific visual acuity requirements.

(b) Annual vision screening of all personnel assigned to positions with laser, microwave, or high intensity light hazards, and biennial vision screening for workers in all other potentially eye-hazardous occupations.

(c) Elective periodic vision screening for employees in noneye-hazardous positions providing the capabilities of the OHS permits. Several installations have provided this service by using youth program summer hires or volunteers under the supervision of the OHN. At others, members of the Division Surgeon's staff have done the elective screening.

(d) Referral for eye examinations and/or care of persons giving evidence of uncorrected visual defects.

(e) Instruction and education of workers about the use and care of eye protective equipment, including contraindications for wearing contact lenses.

(f) Assurance of proper fit of protective eyewear.

(g) Prompt care and/or referral of persons with eye injuries or diseases. This includes teaching workers about preventive and first-aid measures, including proper use of eye lavage fountains.

(h) Identification of employees with useful vision in only one eye.

(I) Maintenance of pertinent records and reports.

(3) Radiation protection. The radiation protection program is governed by numerous regulations. Among these are AR 40-5, AR 40-14, AR 40-46, AR 40-583, AR 50-6, AR 385-80, TM 8-215, TB MED 521, TB MED 523, and TB MED 279. A more complete list is given in "USAEHA Selected References - Radiological Hygiene." The radiation protection officer is responsible for administering the program which involves evaluation and control of industrial and medical ionizing and nonionizing radiation sources. OHS functions within the program include:

(a) Insure that all radiation sources are included in the OHS inventory of hazards.

(b) Provide required preassignment, periodic, and termination medical surveillance, including medical record screening for the nuclear surety program.

(c) Insure that the health records of radiation workers are maintained IAW AR 40-14.

(d) Insure that the DD Form 1952 (Film Badge Application and Record of Occupational Exposure) is maintained for all personnel wearing film badges in the same manner as DD Form 1141 [(e) below]. Coordinate with the RPO in maintenance of the DD Form 1952 [para 4-7b(6)(j)].

(e) Maintain the DD Form 1141 (Record of Occupational Exposure to Ionizing Radiation) (fig E-9) and other records specific to the program. Preferably the DD 1141 will be maintained in the individual health record. However, if a significant number of people are in the program, it may be more practical to keep the DD 1141 forms together in a separate file and to place file charge-out (locator) cards in the individual health record to indicate the availability and location of the radiation record. At some installations the DD 1141 records are maintained by the RPO. In this case, the OHS must coordinate with the RPO to be sure that the OHS has the names of all employees involved and that the charge-out cards are in the medical record. - On transfer or termination, the DD 1141 forms are placed in the medical folder as part of the permanent record.

(f) Assure RPO review of the DD 1141 forms.

(g) Coordinate with the RPO, safety, and others concerned (including community health resources if these may be used for backup support) in development and maintenance of a procedure to handle radiation accidents. This includes periodic practice in the procedures.

g. Other required health evaluations.

(1) These include fitness-for-duty (para 1-3c, FPM 339), disability retirement (para 1-3b, FPM 339 and sec 831.502, subpart E, part 831, FPM chap 990-1, book III), and job transfer examinations. These are provided at the request of the supervisor and/or personnel officer. As with preplacement examinations, these are aimed at determining the individual's physical capability to fulfill the job assignment with safety to himself and others.

(2) Requests for fitness-for-duty and disability retirement ~ examinations (submitted by the supervisor through CPO) should provide all pertinent background data on the reason for the request and any action that has been taken by the supervisor concerning the situation. This is essential for the OHMD to make a valid medical determination. Fitness-for-duty examinations are provided by a Federal medical officer or by a qualified physician of the employee's choice at AMEDD expense.

(3) Job transfer examinations are provided when a worker (military or civilian) is being assigned to a new position with different potential exposures or physical requirements than existed with the previous assignment. Such examinations may also be required for individuals with known chronic diseases or disabilities. The examinations are administered in the same manner as preplacement examinations.

h. Voluntary health evaluations

(1) These evaluations, which are within the lowest priority (Priority 5) for medical care, may range from single disease screening, such as diabetes screening, to general physical examinations. The purposes of these health evaluations are to promote health through early detection and referral for treatment of potential or existing health problems, to provide counseling and guidance regarding individual health maintenance, and to provide a continuous health history.

(2) Because voluntary health evaluations are a lower priority activity, they should be offered only in response to specific, identified local needs or goals and when reasonable returns on the investment of resources can be expected. To determine the need for voluntary health evaluation programs, the OHS staff should review the demographic data (paras 2-5 and 2-9) and trends or prevalence of particular health problems noted on job-related evaluations or the workers' requests for care or counseling. Specific identification of potential health problems that might be prevented or controlled by a voluntary health evaluation program will also include an estimation of the population that could benefit most from the program and/or would participate. For example, glaucoma screening for all persons over 40 years of age is more appropriate than for all persons over 20 years of age. Similarly, nursing health appraisals or general physical examinations yield better results when offered on an age-related basis rather than annually without regard to age. Such discrimination in planning also must take into account optimum use of available MTF or local community health resources. For example, hypertensive screening might be done as part of ongoing OHS programs when workers come into the health unit; as a one-time mass screening program, using resources from other MTF activities; or the program may be offered in coordination with the local Heart Association. In some instances, arrangements to provide disease screening programs have been made with private health service contracting firms. Usually in such cases, the contractor provides a multiphasic screening program, using a mobile unit, and the individual participant pays the contractor for the service. When community health agencies or contractors cosponsor and/or provide the program, they also generally furnish essential equipment; health education and publicity materials; clerical and technical/professional staff; and expertise in planning, implementation and evaluation of the program. Except for occasional difficulty in scheduling a program at a mutually convenient time, the primary problem encountered with outside agencies is related to use and disposition of records of results. Some agencies prohibit giving the results of individual screening tests to anyone but the patient and his personal physician. At most they give the OHS a statistical summary of findings. As a result, the OHS cannot know which workers may have potential health problems, and there is little assurance that the worker has taken any action - or even understands the action to take - to obtain indicated definitive diagnosis or care. Also, the resultant health data do not get into the health record. This problem may be alleviated by advising the employee of the need and giving him the opportunity to designate the OHS/OHMD, as well as his personal physician, to receive copies of the results of the health evaluation program. On occasion, arrangements have been made whereby the health agency has given the OHS the results of individual findings with the agreement that the latter would be responsible for all indicated counseling, referral, and followup. When this is done, participants must be informed as to the disposition of the records of medical findings. Regardless of what arrangements are made, it is important to inform the worker, the private physician, and the local health agency, when used, of the need for the OHS to be advised of potential health problems of the worker so the OHS may assure the problem is not aggravated by the work assignment, as well as to assist the worker in resolving the problem, if indicated.

(3) As stated earlier, the scope and frequency of voluntary health evaluations depend on other priorities, the need for such services, and the capability of the MTF or community health resources to provide the service. While age-related medical examinations may be offered at some installations, usually the available physician time does not permit this. A viable alternative is an age-related nursing health appraisal program. The extent of this program and the standards and criteria to be followed by the nurse in evaluating the findings of the health appraisal are determined by the physician and the OHN. Usually it will include a health and work history; height, weight, temperature, and blood pressure measurements; vision and hearing testing; and when indicated, tuberculin skin testing. Laboratory tests may be included. These may vary from a urine dip stick test to more extensive evaluations, depending on laboratory resources. Electrocardiograms for workers over 40 years of age may be performed if resources permit. When -qualified, the nurse may also include physical assessment and/or glaucoma screening in the health appraisal. Multiphasic or single disease screening programs may be offered in lieu of voluntary medical examinations or nursing health appraisals or as supplements to them. Offering different types of disease screening programs in rotation (e.g., glaucoma, diabetes, sickle cell anemia, etc.) can be an effective means of ongoing health screening for a wide segment of the population. When appropriate, scheduling the programs to coincide with community wide health programs (e.g., hypertension screening in May - High Blood Pressure Month) may provide additional publicity and support for the program. When planning mass disease screening programs, consideration should be given to use of volunteers for both clerical and technical/professional assistance. These may be arranged for in coordination with the Red Cross Volunteer program or through the Civilian Welfare Council.

I. Review and evaluation of findings. This is an inherent part of any health evaluation program.

(1) On an individual basis, the examination or disease screening findings are reviewed to identify any abnormalities so that appropriate action can be taken to control or alleviate their effect. If the abnormality is related to the work assignment, an investigation shall be made as to the reasons for the overexposure and to determine whether or not the worker can safely continue in that particular job. If the abnormality does not appear to be work related, the individual should be counseled and referred to his personal physician, if indicated. Followup must be made to identify the results of referral and to offer additional counseling when pertinent.

(2) Overall program review is essential for epidemiological purposes and to determine the effectiveness of the health evaluation program. For example, when the results of laboratory tests for personnel working with solvents begin to show a trend of increased incidence of abnormal values, an investigation should be undertaken to determine if an overexposure is occurring so corrective action can be taken. Statistical evaluation of disease screening programs will identify whether projected goals have been met in terms of number of participants and anticipated abnormal findings. For example, the estimated prevalence of diabetes in the United States is one percent of the population between ages 25 and 44, 3.3 percent of the population ages 45-54, and 5.6 percent of the population ages 55 to 65. It is further estimated that 50 percent of these are undiagnosed. If the results of a diabetic screening program showed only 0.3 percent were abnormal, this would indicate a need to determine whether the population screened was from the proper age group or whether the screening method used was of an acceptable level of sensitivity. Finally, the results of the programs will be appropriately reported, to include reports of voluntary programs to the workers through such media as installation newspapers or bulletins (para 3-7e).

3-4. Treatment of illness and injury .

a. Purpose and scope . AR 40-3 and 40-5 define the extent of care authorized for occupational and nonoccupational injuries and illnesses. Treatment of illness or injury at the place of work is provided to prevent loss of life or limb, relieve suffering, promote rehabilitation, and reduce absenteeism. The employee has the option of receiving care of occupational injuries or illnesses from the MTF or physician of his choice. Treatment of occupational injuries by the MTF may range from first aid or minor emergency care to hospitalization and definitive treatment and rehabilitation, depending on the need and available resources. While comprehensive treatment may be provided for job-related injuries or illnesses when the MTF has the capability, only emergency or palliative care may be given for nonjob-related conditions. Definitive diagnosis and treatment of such conditions are strictly the province of the employee's Personal physician. On occasion, immediate hospitalization may be indicated for a civilian employee with a major nonoccupational medical emergency. In this instance, the civilian employee may be admitted as an emergency patient at his own expense (AR 40-3) and will be transferred to a community health care facility as soon as it is medically feasible. The personal physician is then kept informed about the progress of his patient while in the Army MTF.

b. Provision of care . As a minimum, arrangements must be made for provision of emergency care at all times, transportation of ill or injured, and informing supervisors and employees on procedures to follow in the event of injury or illness. Procedures for these arrangements should be spelled out in the OHS SOP.

(1) Where the OHS is colocated with a MEDDAC or MEDCEN, initial care is usually the responsibility of the emergency room (ER), a walk-in clinic, or the TMC. In some circumstances, the OHS may have the capability only to treat minor emergencies, with all major emergencies being referred to the MEDDAC/MEDCEN hospital. In either case, the ER provides coverage for evening and night shift personnel. Where there is no colocated hospital, the OHS provides all primary care, referring patients to other federal or community health care facilities when it lacks the capability for the required treatment. After normal duty hours emergency care at these installations may be provided by firemen or security guards trained in appropriate first aid procedures, local rescue or emergency squads, or occasionally, depending on local requirements, a medical technician assigned to the evening and/or night shifts.

(2) Transportation coverage will include arrangements to take health-care personnel to the emergency at the worksite if necessary, to bring the patient to the MTF, and/or to take the patient to other health care facilities when more definitive or extensive treatment is needed. This includes use of installation or other ambulance services, other official personnel vehicles, or privately-owned vehicles. When official vehicles (either Government owned or under Government contract) are used, they should be operated by designated, trained drivers and attendants. Private vehicles should be used only when no official vehicle can be made available or when medical evaluation determines that an official vehicle is not required. POV operators will be properly licensed. When nonofficial (e.g., commercial ambulances) vehicles are used to transport employees with nonoccupational conditions to local community medical facilities, the cost will be funded by the employee. Usually this is covered by the employee's health insurance.

(3) All personnel in the work environment (supervisors and workers) must be kept informed about what to do when there is an injury or illness. This includes when and how to summon medical assistance, as well as what not to do to protect the injured.

(4) Planning for major disasters is done in coordination with other MTF and installation personnel (para 4-9b).

c. First aid.

(1) First-aiders should be available to assist the health service staff in the event of a major emergency and to provide first aid for injuries or illnesses, with appropriate referral, when the OHMD or OHN are not available, such as on second or third shifts. They may also provide first aid care at locations distantly located from the health service unit, and must be available where there is a potential hazard for which specific immediate care is essential and where any delay would endanger the victim. Selection of workers for this responsibility should assure that there is at least one trained first-aider on duty for each major work area and shift. The names, duty location, and hours of work for these first-aiders must be available to the health service staff, and supervisors and employees must be kept informed as to who the designated first-aiders are. For example, lists of approved first-aiders may be posted on work area bulletin boards. It should be emphasized that first-aid personnel are only supplementary to and are not substitutes for the health service staff, and that the care they are authorized to give is limited. Selection of first-aiders is usually done by supervisors from workers who volunteer to provide the service. Arrangements for first aid training are made by installation personnel training officers or the training may be obtained from community resources.

(2) All first-aiders must be currently trained in first aid by such recognized training sources as the American National Red Cross or Bureau of Mines. Preferably, the training will include cardio-pulmonary resuscitation techniques. At locations where overexposure to specific highly toxic hazards will cause a rapid body reaction, all personnel potentially exposed to such hazards will be fully trained in the first aid measures to be taken in the event of an overexposure and participate in regular emergency practice sessions. All personnel working with high voltage electricity shall be currently certified in CPR procedures.

(3) When firemen, guards, or other installation personnel are authorized to give first aid care in the absence of the physician or nurse, they shall be provided with written instructions by the physician in charge, specifying the type and extent of first aid care they may give, medical or health care referral resources to use, and procedures to follow in referral and/or transportation of individuals requiring more than first aid.

(4) Placement of first aid kits in work areas is discouraged when MTF's are readily available (app J). When assignment of kits is medically approved, they should be located near handwashing facilities. Contents of the kits will be limited to items required for specific hazards or to those items necessary for care until the individual can be treated at a medical facility. All kits should be checked periodically (i.e., at least annually) by OHS personnel. This is in addition to more frequent checking of the kits by the assigned first-aider or his supervisor. In instances where firemen or guards have access to the occupational health clinic facility when giving first aid care after normal duty hours, only first aid materials should be available in the clinic for their use. All other OHC treatment materials and medications must be properly secured.

(5) All first aid care, regardless of where it is given, will be recorded and reported to the OHS and to the safety office. This may be accomplished by use of a log sheet maintained with the kit, use of DD Form 689, Individual Sick Slip (fig E-10), or similar injury and illness report forms. Minimum data required are date, name of patient, site and type of injury/symptom of illness, cause, treatment given, disposition when indicated, and signature of first-aider. Information from these reports should be recorded in the individual health record.

d. Treatment principles and procedures. Effective, efficient treatment of illness and injury, whether or not the condition is job related, depends on conformance with certain basic principles and procedures. Failure to conform may result in poor patient care, unnecessary interruption of mission accomplishment, and disruption of effective health service working relationships with installation personnel. These basic principles apply wherever the treatment is provided - in the OHC, ER, TMC, etc. Further, all health care personnel must remember that the prognosis and eventual rehabilitation of the patient are directly affected by the initial care given.

(1) Before giving any treatment, carefully assess the individual's condition to identify the extent and priorities of care required. This assessment should be accomplished quickly and thoroughly to assure proper patient care. It should include:

(a) Careful, comprehensive observation of physical signs, as well as any indicators of the patient's emotional status.

(b) Patient's description of subjective symptoms.

(c) Complete history of the illness or injury (when, where, and how it occurred or developed) from the patient and from witnesses when applicable.

(d) In the event of a suspected occupational illness, review the potential exposures at the worksite and other possible exposure sources, such as hobbies, home repair work, second jobs, etc.

(e) Review of past health history.

(2) On the basis of the initial assessment, take appropriate action to assure safe, proper care of the patient.

(a) Do first things first. Life saving measures take precedence. When more than one patient is involved, the principles and procedures of triage should be applied.

(b) Send for the physician promptly, if indicated. When a patient will be referred for medical care and/or hospitalization, give only the treatment essential to the patient's safety and comfort. Avoid interference with subsequent treatment. The physician or hospital personnel should be alerted when a patient is being sent to them, and should be provided with precise information, preferably in writing, regarding the incident and all treatments and medications given the patient.

(c) Administer the treatment indicated as authorized by the medical directives or as ordered by the physician. Treatment will be given promptly and efficiently, utilizing recognized procedures and aseptic techniques (FM 8-36, TM 8-230). Before administering any medication, be sure the patient has no allergies or other contraindications to the treatment.

(d) If called to the worksite for an emergency, give only that treatment required to permit safe transportation of the patient to the MTF.

(e) Keep only those persons needed (first-aider, supervisor) to assist with the emergency. Have all others sent to their duty stations.

(f) Keep the patient as calm, reassured, and comfortable as possible.

(g) Avoid further injury or illness. Even when treating minor illness or injury the patient should not be kept standing.

(h) Provide health education/counseling as indicated.

(i) Make and/or assist with referrals for further care, as indicated, including advising supervisor about any physical limitations of the worker.

(j) Assure complete, concise recording in individual's medical record of all injuries and illnesses, regardless of severity, and completion of all required forms and reports (para 4-7).

(k) Followup as indicated.

(3) Facilities and equipment shall be ready at all times for anticipated emergencies. This includes maintenance of emergency equipment for use for in-plant emergencies as well as for emergencies occurring in the MTF. These will be equipped IAW the physician's direction and the type of emergencies that may be expected at the installation.

(4) At installations where emergency care is provided by one or more MTF other than the OHS, arrangements must be made to be sure all such care is recorded in the occupational health record of civilian employees, and that the OHS is advised about all military personnel occupational (vs line-of-duty) injury and illness incidences (see definitions in app C). This requires close coordination between the OHS, the supporting MTF (ER, TMC, DPCCM), Division/Flight Surgeons, and the safety office. Where no system has been established, the OHMD and/or OHN must initiate action with the concerned personnel to set up a system that is compatible with the needs and capabilities of the installation. This should take into account all reporting requirements (medical, safety, Office of Workers' Compensation Programs) (para 4-7).

e. Epidemiologic investigations. Epidemiologic investigations shall be conducted on all suspected or proven occupational illnesses and of unusual or increased incidence of occupational injuries. Such investigations should be coordinated as indicated with PVNTMED (industrial hygiene), safety, hospital infection control officer, Division or Flight Surgeons, and/or other installation personnel who may have an interest or responsibility related to the problem. Additional epidemiologic support may be obtained, when needed, from the supporting MEDCEN and/or USAEHA. Epidemiologic investigations may range from a simple review of the work and health history and onsite evaluation of the exposure to an indepth study involving laboratory analysis of the suspected agent(s), literature review, etc. (app H). Such indepth investigations frequently require the support of USAEHA, which is requested through channels (para 1-5). When there is an acute outbreak and/or local and MEDCEN capabilities are limited, USAEHA may be contacted by telephone for guidance. Outbreaks of occupational illnesses (civilian and military) are telegraphically reportable (Section III, AR 40-418) to DASG for epidemiological purposes.

3-5. Immunizations and communicable disease control. AR 40-5, AR 40-26, AR 40-562, and TB MED 114 define the scope and procedures of the Army immunization and communicable disease control program for military and civilian personnel.

a. Occupational health aspects of the program are aimed at prevention of disease related to potential occupational exposures (rubella, tetanus, tuberculosis, hepatitis, meningitis, etc.) or anticipated epidemics (influenza), and at meeting official international travel requirements.

b. Determination of which immunizations will be given, whether on a required or elective basis, shall be made by the physician IAW DA policy and his assessment of the extent of the problem, the potential effectiveness of the immunization program in preventing or controlling the problem, and Centers for Disease Control (CDC) guidance. For example, employees with a high potential risk of tetanus may be required to maintain their protection against it. Specification of requirements and planning of the immunization program for MTF/patient care staff must be coordinated with the hospital infection control committee.

c. Administration of immunizations may be done at the immunization clinic, TMC, or the OHS. Regardless of where immunizations are given, a system must be established that assures that all persons requiring job-related immunizations are identified and referred for the appropriate immunization, that these are recorded on SF 601 (Health Record Immunization Record) in the individual medical record, and that the OHS is kept informed when all such immunizations are given. Usually, job-related immunizations are given in conjunction with preassignment or periodic job-related health evaluation. The elective influenza immunizations may be administered in the MTF or at the worksite. In either instance, appropriate provisions must be made to handle any anaphylactic reaction that may occur (AR 40-562).

d. The tuberculosis control program includes job-related medical monitoring (tuberculin skin testing) of personnel potentially exposed in their work assignments (AR 40-26). Those individuals suspected of having the disease or who are contacts of persons with active tuberculosis will be provided appropriate referral and followup. This program should be coordinated with the PVNTMED Activity (preventive medicine officer, community health nurse) and/or local public health personnel. Where the OHS is colocated with the PVNTMED Activity, there may be a division of the tuberculosis control workload. For example, the community health nurse may conduct the program for military and military beneficiary personnel and the OHN may conduct the program for civilian employees. In such cases there must be a clear definition of how the workload is divided to be sure all military and civilian employees are included as applicable, to avoid duplication of effort and assure that all necessary followup is conducted, to include maintenance of the tuberculosis followup file.

e. Other communicable disease control activities include:

(1) Education of workers regarding proper handling of infectious wastes, etc.

(2) Surveillance of food handlers, patient care personnel, and other workers who have close contact with people to prevent their working while having an infectious disease.

(3) Encouraging all employees with upper respiratory infections to use their sick leave while in the infectious state and to take proper measures to prevent and control such illnesses.

(4) Surveillance of men and women employees (military and civilian) with potential exposure to rubella (hospitals, clinics, child care facilities) to assure they are included in the rubella protection program.

3-6. Occupational health for MTF personnel. The policies, principles, and practices of OH for personnel working in an MTF are the same as for any employee group. However, because of the increased potential exposure to infectious agents in the MTF work environment, particular emphasis is needed in the area of infection control to protect not only the worker and his coworkers, but also his patients. This applies to both inpatient and outpatient care facilities. The hospital infection control program described in AR 40-5 stipulates that the hospital infection control committee will, among its various functions, assist with the infectious disease aspects of the OH program for MTF personnel. Therefore, close coordination is required between the OH staff and the hospital infection control personnel to assure accomplishment of the program. Coordinated activities should include:

a. Identification of potential infectious agents and of high risk areas (e.g., ICU, nursery, blood bank, laboratory, laundry, etc.) and the personnel assigned to these areas.

b. Determination and assurance of provision of required preplacement and periodic medical surveillance. Assurance that a history/incidence of childhood communicable diseases and other infectious diseases are recorded in the baseline and interim health histories.

c. Definition of requirements and priorities for immunization protection for all MTF personnel and assurance that immunization levels are maintained.

d. Establishment of a system to assure prompt reporting, treatment, and followup of all MTF personnel incurring injury or illness at work, to include all infectious conditions regardless of cause, and for epidemiologic investigations when required.

e. Development and ready availability of specific SOP for MTF and OH staff to insure prevention and/or proper management of individual occurrences or outbreaks of infections (e.g., infected needle sticks, rubella, herpes virus, diarrheal disease, ARD, TB, etc.).

f. Initial and continuing education of MTF personnel in the principles and practices of prevention and control of infectious diseases, as well as other work related illness and injury, with emphasis on the importance of reporting all such conditions to the OHS and/or infection control officer.

g. Representation of the OH staff on the hospital infection control committee to insure essential coordination of infectious disease related activities.

3-7. Health education and counseling. The provision of information, guidance, and counseling support to assist workers improve and maintain their health is an essential aspect of the OHP. It begins with the worker's first contact with the health service personnel and continues throughout his tour of duty. It can range from informal, unplanned counseling of an individual regarding a relatively minor health problem to an extensive disease prevention education campaign (app K) that utilizes varied educational means and media. First priority must be given to education related to job health hazards. In terms of results (i.e., changed behavior or attitudes), the most effective health education counseling is that given when an individual or group requests it or when the subject matter is of immediate and personal concern to them. Thus, the OHS staff should be alert to and use every such opportunity for health education. Some of the more common OHS health education activities include:

a. Health education about job health hazards. This is required by law and primary responsibility rests with supervisors. However, supervisors need the support and guidance of safety, occupational health, industrial hygiene, and civilian and military personnel training staff in meeting this requirement. In particular, OHS staff should advise about or assist in presenting health (versus safety) aspects of job hazards. This includes signs and symptoms of overexposures, self protection measures (wearing and care of protective equipment, importance of cleanliness, etc.), first aid actions in the event of overexposures (including operation/use of eye lavage fountains), etc. OHS support of job health hazard education may be accomplished at new employee orientation sessions, during worksite visits, when conducting health and work histories for preplacement or periodic examinations, at special group sessions to include supervisors' weekly 5-10 minute safety briefings for their workers, and/or by providing or advising about hazard specific educational pamphlets.

b. Orientation of new workers. This usually includes a briefing as to the installation OHP, its resources and limitations, and how the worker may utilize these most effectively. Such orientation may be given individually when the new worker reports for inprocessing after hire or it may be presented to groups of new personnel either as a part of, or separate from, the civilian personnel officer's general orientation program for new employees. A number of installations have found it useful to develop printed leaflets or fact sheets briefly describing the health service, its functions, hours of duty, and how to utilize its services (app L). These are distributed to new employees at the time of their orientation to reinforce the information given verbally. In addition, the DA film, "Partners In Health" (TF 8-6035), available through Army Training and Audiovisual Support Centers, is a useful aid in orienting new employees to the OHP (app M).

c. Orientation and/or training of supervisors. Supervisors are responsible for the health and safety of their workers and should be advised how the OH staff can assist them in meeting this responsibility. Most frequently such orientation is given as a part of the installation supervisory training program and/or at supervisors meetings. However, individual guidance related to specific problems, may be needed. In general, subject areas that may be covered in group or individual sessions for supervisors include:

(1) Information on the purpose and scope of the OHP and when and how workers should utilize its services.

(2) Consultation and related services available to supervisors concerning health problems of workers.

(3) Procedures for referral of workers to the health service for various reasons, including clearance before or after sickness absence, pregnancy reporting, and special health problems.

(4) Procedures to be followed by the supervisor and worker in processing various health service record and report forms (para 4-7).

(5) Information about new or special health programs, including plans for coordinating these with supervisors who may be involved.

d. Individual or small group counseling regarding general health protection and maintenance. For individuals, general health promotion is most frequently done when they come to the OHS for care or otherwise approach the OHS staff with questions or problems. Small group sessions may be set up when a group of workers is identified as having a common health problem and request help with it. Examples of health problems that may be dealt with by individual or group counseling include:

- (1) Diabetes, emphysema, or other chronic disease problems.
- (2) Obesity.
- (3) Effective use of medical support systems, including personal physicians, community disease detection or other health resources, etc.
- (4) Health aspects of retirement.
- (5) Seasonal health topics.

e. Preliminary orientation and followup information on the purpose and content of special health programs. Where possible, the introduction to such programs should be done via discussions with worker groups (by departments, sections, etc.) to enable them to raise and clarify questions as well as provide better opportunity to encourage them to take advantage of the program. In lieu of this, the support of supervisors may be enlisted, supplemented by articles, printed leaflets, or similar materials and, possibly, through public address system announcements. The program followup should inform participants and others concerned (in addition to the individual counseling, referral, and followup) about the overall results of the program. For example, this might be done in an article in the post publication summarizing the program activities, number of participants, number of referrals, and reactions of participants. When feasible, photographs taken while the program was in progress add to the effectiveness of these articles.

f. Provisions of health education materials (pamphlets, posters, audiovisual aids). The CHN and local public or voluntary health agencies are good sources for such materials (many available at little or no cost). Job hazard education materials are available from safety, OSHA, NIOSH, the National Safety Council, and some voluntary health agencies. USAEHA Technical Guide 125, Occupational Health Education Index, provides a quick reference for available job-related health education materials. When appropriate materials are needed but are not available through regular channels, they may be developed by OHS staff with assistance from installation PIO or related resources.

g. Preparation of health articles or briefings for installation publications. These, as with the pamphlets, may deal with any of the health education activities or topics mentioned above. Again, coordination with PIO or personnel offices may facilitate development and dissemination of the information.

h. Assistance with teaching medical self-help and/or first aid courses.

When resources permit, the OHS staff may give or assist with the teaching of these courses providing those aspects relate to occupational health (e.g., CPR).

3-8. Sickness absence control-medical support. Absenteeism control is the responsibility of the supervisor and personnel officer. However, the OHS staff can and should make significant contributions to their efforts when the absenteeism is illness related. Directly and indirectly, various aspects of the OHP (health evaluations, disability surveillance, health education, etc.) have an impact on the control of sickness absence. More specifically, the OHMD and/or OHN should keep the personnel officer informed regarding the potential capability and contributions of the OHS that may influence personnel and supervisory policies for absence control. OHS activities will include the following:

a. Clearance, treatment, or referral of employees wishing to leave work during duty hours for reasons of illness, is aimed at assuring proper care, as well as conserving lost time. Frequently, palliative treatment may be given that enables the individual to finish out the workday. On the other hand, the OHN may identify 2 potentially serious problem that requires immediate referral. On the basis of the assessment of the employee's health problem, the OHN may:

- (1) Administer nursing care indicated and advise the individual to return to duty.
- (2) Counsel the individual regarding personal health maintenance, health services resources, and other factors related to prevention or control of the health problem.
- (3) Refer the individual to the OHMD, his personal physician, or other medical resource indicated.
- (4) If the individual is being referred immediately to an outside physician or hospital, assure that safe, proper arrangements are made for his transportation to include ambulance service if needed.
- (5) Provide the referral source with pertinent information regarding the patient's condition. treatment given. etc.

b. Clearance of employees returning to duty after illness absence is done to assure they are able to return to work, to identify any physical limitations for work, to identify and record any chronic diseases or other health problems, and to provide health counseling. Usually, installation regulations routinely require medical clearance only for employees with absences due to occupational illness or injury and for those who have had a sickness absence of specific duration (e.g., 5 or 10 work days). In addition, when the supervisor has a question about proper use of sick leave, he may request such clearance for shorter periods of absence for specific employees (IAW FPM 630). This OHS evaluation may include:

(1) Interview and screen (i.e., temperature and blood pressure) the employee to determine extent/severity of illness and present health status and to assure employee is able to return to his job.

(2) Consultation with the personal physician to obtain further information regarding the health problem, and/or give him information about the physical requirements of the patient's job and health service resources.

(3) Referral to the OHMD when there is a question of the individual's readiness to return to work.

(4) Counsel of the employee about precautions to take to avoid exacerbation or complication of the health problem.

(5) Advise the employee's supervisor regarding any temporary or extended limitations of the employee's capability to perform his job.

c. Clearance of food handlers and MTF/patient care personnel before return to work after any infectious illness is aimed at controlling disease transmission.

d. Review of health service records, sickness absence records, supervisors' referrals, and other indicators may identify individuals with potential health problems that might be prevented or alleviated by appropriate occupational health intervention. For example:

(1) Supervisors' review of personnel taking sick leave may reveal employees with apparently minor but persistent health problems, such as the young woman who misses one to two days about the same time each month, or an individual with frequent one or two day absences. On referral, the nurse should review the health records of persons so identified and check with the individual's supervisor to get all available information. Then, if a health problem is apparent, the nurse should arrange to consult with the individual to determine if he is under the care of, or should be referred to a physician. Additional guidance regarding personal health maintenance or handling the health problem would be given as needed.

(2) Referrals from supervisors can identify workers who are absent on extended sick leave and who may benefit by some type of followup by the OHN. The supervisor may have considerable information about the employee, his health problem, his anticipated return to duty, and he may be keeping in contact with the employee directly or through his family. In such instances, there may be no need for the OHN to be involved. Or, she may need to contact the employee, his family, or his personal physician to advise them of supporting services that may be available from the health service and/or determine the prognosis as it relates to the individual's return to duty. Such contact, whether by phone or in person, can facilitate the individual's return to work and also serve to promote more effective relationships with all concerned.

(3) At no time should the OHN (or other OHS staff persons) be used to "check on" suspected malingerers. Identification and control of the abuse of leave benefits is a supervisor/personnel responsibility. If there is any question as to whether the OHN is being asked to check on a malingerer rather than to assist with a health problem, the matter should be resolved by the OHMD, or - in his absence - the C, PVNTMED. If the OHN and OHMD decide that the nurse should contact an absent employee and finds the employee is not ill, this should be reported only to the OHMD. At the same time, the OHN has a responsibility to counsel the worker about the proper use of sick leave.

(4) A review of health records may indicate a health problem common to a number of employees. In such cases, rather than counseling them individually, it may be more practical to develop a group counseling or education program.

3-9. Chronic disease or disability surveillance. Identification and periodic follow-up of employees with chronic diseases or disabilities are important means to assure that the individual's optimum health status is maintained and that no adverse affects result from interactions of the job with the illness or disability. Guidance for the program (which employees and/or disability categories should be included; and the extent, frequency, and duration of followup) is given by the OHMD to the nursing staff which has the main responsibility for carrying out the program.

a. Employees with chronic diseases or disabilities may be identified in a variety of ways. Preplacement or periodic physical examination procedures will reveal previously known or new health problems. Disease screening programs may identify persons with previously unknown conditions. Individuals on, or returning from, extended sick leave may report new disease conditions. An initial collection, or periodic updating, of the essential data may be accomplished by asking employees to provide the OHS with pertinent information about any continuing medical problems, their treatment, and source of medical care. If a form is developed to gather the information, development and use of the form must be IAW the Privacy Act and forms development requirements [para 4-7a(5)].

b. Each chronic health problem will be recorded in the individual health record in such a way that the information will be easily noted by anyone giving care to the patient. This is particularly important for the worker whose disability has a direct relationship to his ability to do his job in a safe, healthful, and productive manner.

(1) Marking the medical problem box on DA Form 3444 (Terminal Digit Folder) when this form is used, and/or affixing special stamps or labels [para 4-7b(4)3 may be used to identify the fact of disability on the health record jacket.

(2) Specific information about the disability should be recorded inside the health record. Preferably, this will be done through use of HSC Form 79, Medical Problem List, [para 4-7b(4)] or similar summary form; by notations on SF 600; and/or use of CSC (OPM) medical report forms for specific diseases [para 4-7b(6)]. The data required include:

(a) Specific diagnosis and evaluation of limitations and/or abilities for work and related activities.

(b) Routine medications or treatments being given to the patient.

(c) Instructions for emergency medical or nursing procedures.

(d) Name, address, and telephone number of the personal physician.

(e) Name, address, telephone number, and relationship to the worker of person(s) to notify in case of emergency (such notification is usually done by the supervisor or CPO).

c. The frequency of periodic followup by the OHN will vary, depending on the situation and the OHMD's guidance. Workers returning to duty after cardiac illness or recently diagnosed diabetes may require more frequent followup initially than those whose condition has stabilized. Certain types of disability (amputee, monocular vision) need less frequent contact, but care should be taken that they are cleared by OHS before any job transfers that may involve a change in physical fitness requirements. The followup may consist of only a telephone call to inquire about the health status and offer counsel, or it may involve a visit by the worker to the OHS for screening tests and more thorough interim health history and counseling. For recently diagnosed conditions, the OHN should be prepared to reinforce or clarify the personal physician's instructions regarding treatment and self-care. If there is any doubt about the instructions, the nurse should consult the personal physician for his direction.

d. Persons with chronic disabilities who take certain types of medications (anticoagulants, etc.), have allergies or drug sensitivities, or who wear contact lenses should be encouraged to wear medical warning tags. This may be the "Medic Alert" tags that the individual may purchase from commercial sources, or the Army Medical Warning Tag authorized in AR 40-15. (Note: The "Medic Alert" tags have also been used by individuals who wish to be organ donors.)

3-10. Pregnancy surveillance. The purpose of the pregnancy surveillance program is to determine the safety and health factors of the work environment of the pregnant employee (civilian or military), to assure that no adverse effects to her or the fetus will result from her continuing to work, and that she is under the care of a physician. The program is primarily the responsibility of the OHN IAW guidelines developed by the OHMD. For military women, the program may be coordinated with and implemented by the CHN or OB/GYN nursing staff. The usual elements of the program include:

a. Health and work history and interview of the employee when she first reports her pregnancy. Data will be recorded on SF 600 regarding expected date of confinement; previous pregnancies; and job assignment, exposures, and hours of work. Several installations have developed a form letter requesting data from the personal physician (fig 3-2). DA Form 4254R (Request for Private Medical Information) (fig E-11) or DA Form XXXX-R (Authorization for Disclosures of Information) (AR 40-66) (fig E-12) may also be used for this purpose. Any request for personal medical information will include the employee's written authorization for the release of the data.

b. Evaluation of the pregnancy in relation to the job. If the woman is in a job position that may interfere with the normal course of pregnancy or where she is exposed to teratogenic or fetotoxic substances, the OHMD supervisor and/or personnel officer will be notified so they may make arrangements for a change of assignment. When no suitable positions are available, the woman and her physician will be consulted so a decision can be made concerning the continuation of her work status.

c. Periodic counseling and reevaluation of the work assignment. Usually, if the pregnancy is normal and the job environment is safe, there is no requirement for periodic followup of the pregnant employee unless requested by the employee or her physician. However, when questions arise during the pregnancy concerning the woman's physical status or job, they will be referred to the personal physician and/or OHMD as indicated.

d. Assessment of the health status of the woman on return to work after maternity leave. Questions related to the woman's readiness to return to work should be referred to the personal physician when necessary and/or a written authorization for the employee to return to work may be requested. The OHN may also provide guidance regarding infant care facilities and related concerns of the employee.

LETTERHEAD

TO: _____
(Name of attending physician)

(Name of employee) is employed at (name of installation) as part of our Occupational Health Program. We request your guidance about whether she is able to continue working in her current job during her pregnancy. Her work assignment includes potential exposure to _____. If you need further information, please contact me at (insert telephone number).

(Signature of OHMD or OHH) (Date)

EMPLOYEE'S AUTHORIZATION

I hereby authorize Doctor _____ to release medical information to
(insert the name of the OHMD or OHH and the installation).

(Employee's signature)

(Employee's name printed/typed)

(SSN) (Date)

ATTENDING PHYSICIAN'S STATEMENT

It is my professional opinion that she (is) (is with the following limitation)
is not physically able to continue working in her present job until _____
(Date)

COMMENTS _____

(Attending Physician's Signature) (Date)

(Address)

(Telephone Number)

Figure 3-2. Example of form letter requesting pregnancy data

3-11. Alcohol and drug abuse prevention and control program. Programs for the prevention and control of alcohol and drug abuse are mandatory and a command responsibility. AR 600-85 and DA Pamphlet 600-17 define the policy and scope of the program that is usually administered by the civilian and military personnel offices. FPM 792-9 and Supplement 792-2, Employee Counseling Services Program, extends the ADAPCP to include other medical, emotional or behavioral problems that can affect an employees performance. OHS coordination in the program includes:

- a. Assistance with gathering information for development and maintenance of a list of available health-related referral resources.
- b. Assistance with case finding and referrals.
- c. Counseling personnel in the program, when indicated, in support of the AOAPCP counselors and supervisors.
- d. Assistance with orientation of supervisors and others, as indicated.
- e. Inclusion of alcohol and drug abuse prevention and control in the overall health education program.
- f. Provision of health evaluation for civilian personnel entered in the program when indicated.
- g. Administration of medications (antabuse), when indicated.

Section III. Occupational Health Program Evaluation

3-12. General.

a. The purpose of OHP evaluation is to insure that the program:

- (1) Meets legal, regulatory, and professional requirements
- (2) Meets the health needs of employees
- (3) Makes optimum use of all resources
- (4) Has the flexibility to meet changing demands and resources for services
- (5) Is of high quality
- (6) Uses the most effective and efficient methods or approaches, and
- (7) Achieves health care goals.

b. Primary responsibility for program evaluation rests with the OHMD and/or OHN. They should coordinate this activity with other OHS staff members, the industrial hygienist, and - as indicated - with the Chiefs of PVNTMED or DPCCM and others involved in the OHP. In addition, input may also be solicited from installation safety, personnel, and supervisor/employee recipients of OH services. Responsibility for evaluation includes not only performing the evaluation but also making sure that all concerned are informed about the findings and that corrective action is recommended or initiated when indicated. A summary of the important findings of the evaluation should also be included in the Preventive Medicine Activity (PMA) annual historical report. This is an important mechanism for keeping command informed about the progress of the OHP, its accomplishments, and areas needing added emphasis or support.

c. Ongoing and periodic evaluation is essential to having an effective and efficient service. The process of evaluation documents what is being accomplished, any existing unmet needs or weaknesses, and whether the results have been worth the expenditure of funds. Evaluation also identifies changing occupational health needs that must be addressed, such as changes in installation operations or population that indicate a need to add, drop, or change existing program elements. The annual OHP evaluation will cover all elements of the program and OHS activities.

d. Meaningful evaluation must be based on sound planning and clearly established program objectives. In fact, in a dynamic OHP, evaluation and planning are closely related. Evaluation is based on objectives, activities, and resources. Planning and revision of objectives, activities, and resources are, in turn, based on evaluation findings.

3-13. Evaluation methods and tools.

a. It is essential for evaluation methods and tools to be built into program planning. When program objectives are defined, what will be needed to validate that they have been met? What data or evidence should be collected? How/where can it be obtained? Who will be involved? What data processing resources are available? What standards are available to measure the program. For example, evaluating the hearing conservation element of the DHP would be based on the objective: to prevent hearing loss in all employees working in hazardous noise areas (e.g., noise level exceeds 85 dBA). Since, with certain exceptions such as highly susceptible individuals, noise-induced hearing loss is considered to be almost completely preventable, the standard of achievement for a fully effective hearing conservation program would be no noise-induced hearing loss among the potentially exposed individuals. Data needed to document this will include number of personnel potentially exposed to hazardous noise, personnel receiving audiograms and issued hearing protectors, personnel found to have noise-induced hearing loss, etc. The sources of such data are OD Forms 2214, 2215, 2216, and 2217 and/or data available from the audiologist, safety officer, PVNTMED technicians, audiometric technicians, OHS or other MTF clerks, patient health records, daily logs, etc. In addition to statistical data, OHS staff observation of employees wearing hearing protectors in the noise-hazardous work areas is a method of evaluating the effectiveness of education provided employees and supervisors regarding the use of hearing protection and the level of Command support that has been obtained.

b. Usually, the resources necessary for program evaluation are already available. It's primarily a matter of identifying and using them. Whenever possible, data processing resources should be used to compile the statistical data. ADP staff can be very helpful in designing data collection tools for evaluating ongoing and special programs. A major essential resource for effective program evaluation is the personnel involved. Without the informed cooperation of all concerned, no evaluation process can be complete. Wherever indicated, health clinic staff and others who may be concerned should be informed and involved, as appropriate, in the process. The staff nurse who is asked for suggestions on what might be included and the clerk who knows why certain information is needed are more likely to provide more complete and thoughtful input into their aspects of evaluation than if they are only told to "do it."

(1) The DA Form 3076 (Army Occupational Health Report) (fig E-13), and DLA Form 1013 (Occupational Health Report) provide the primary tools for overall program evaluation (para 4-7). While these reports are submitted semiannually and annually, respectively, the data will be collected on a daily basis and summarized and reviewed at least monthly. This will help insure that essential data are being collected and will alert the staff to any changing trends or problems that should be taken care of promptly. The monthly and annual review should be related to previous comparable report periods, as well as to program goals, in order to identify areas of program growth, decrease, or omission. The narrative documentation of the statistics should also define special problems and their cause and solutions, as well as special accomplishments or positive results of specific programs or activities. Personnel having input to the report data should be involved in the report review, particularly if there are questions, and to get their ideas and comments on how and where the collection and use of the data may be improved to facilitate program effectiveness. Injury and illness incidence, will be correlated with that required for the OSHA report [para 4-7e(7)(e)] and discussed with the safety officer.

(2) Special or one-time programs usually will require development of specific evaluation tools. For example, evaluation of a one-time glaucoma - screening program will require a tool or system that identifies the number of people screened, the number of people with questionable findings that are rescreened, the number referred for definitive diagnosis and treatment, and the number of individuals finally diagnosed and on treatment or being observed by their personal physician. In addition to the statistical data, records should be kept of positive or negative comments of personnel being screened, as well as staff comments or suggestions for improvement of the efficiency of the screening activity. Evaluation of health education activities is more difficult. Pre and post-presentation questionnaires might be used in some situations to determine how much new knowledge recipients gained. Observation and documenting use of protective equipment, or decreased incidences of particular types of injuries (e.g., eye injuries) offer other means to determine effectiveness of health education programs. The frequency and effectiveness with which employees and supervisors use the health service facility may indicate how much they have learned from employee and supervisor orientation and training programs. Necessarily, some of this data collection and evaluation may be subjective. But, so far as possible, every effort should be made to determine objectively what the OHP is accomplishing and where it can be improved to meet the needs of the installation and the personnel served.

3-14. Occupational health unit performance evaluation. To some extent evaluation of health unit performance is inherent in evaluating program effectiveness. However, there are specific areas (staff, facilities, and equipment) that must be considered.

a. In relation to staff, are ON personnel performing at a level commensurate with their training and experience, or are professional nurses doing clerical work? Are personnel trained in audiometry performing audiometry or is audiometry done by whomever happens to be available at the time? Is the work being done actually the responsibility of the OHS? for example, is the Civilian Personnel Office notifying civilian employees of appointments or is the OHS notifying employees? Are volunteers utilized? Often, Red Cross volunteers can perform many tasks required in an OHS. Can some functions be performed by someone other than the OHS staff? For example, can and will the local chapter of the American Cancer Society provide classes in breast self-examination? These and other aspects of personnel evaluation are discussed in paragraph 4-12d.

b. The use of facilities should be looked at from the standpoint of adequacy, efficiency of layout for both staff and patients, and availability to personnel served. Is there enough space for patient waiting and treatment areas or for staff administrative functions? Must patients or staff retrace their steps frequently to complete a physical examination? Can arrangements be made to take a screening program to the work site, rather than bringing workers to the health facility? Paragraph 4-6a discusses facility planning and use in more detail.

c. Equipment evaluation will consider adequacy, efficiency of operation, and availability. Adequacy includes both quantity (are there enough audiometers and booths for the number of audiograms done?) and appropriateness (a stereoptic vision screener is recommended rather than only Snellen and Jaeger charts in order to cover all the vision parameters needed). Efficiency of operation includes ease of operation and special training requirements for operators, accuracy of results, cost of materials, time factors, etc. Availability includes location (is the spirometer in the OHS, the MEDOAC hospital, or at a contracting medical clinic) and access (can x-rays or laboratory work be done at anytime or must they be scheduled for certain days?) Paragraph 4-6b discusses equipment planning and use more fully.

3-15. Reporting program evaluation.

a. Reporting of OHP results is an essential part of the evaluation process if appropriate use is to be made of the data by those concerned. This reporting starts at the installation level where any action to improve performance or effectiveness must start. This may include reporting within the health unit, to the MEDDAC/MEDCEN Commander, to the installation Commander and staff, to employee groups, etc. When indicated, reports or copies of reports should be forwarded to higher headquarters (medical and, possibly, other MACOM). Paragraph 4-7 discusses required reports in more detail. While these are primarily statistical reports, they can be made more meaningful through the addition of brief pertinent narrative comments.

b. Since the distribution of required reports is limited, other means of disseminating the results of the OHP may be desirable. This may apply to one-time or infrequent special programs, or it may be indicated to promote continuing health care programs. As noted earlier, a method frequently used for doing this is the publication in the installation bulletin or other news media of an article describing the program and its results. In this case, the inclusion of short anonymous case studies makes the report more readable and interesting.

c. In addition to required and local reporting, there is a real need to report on OHP and OHS activities to a wider audience both within and outside of the Federal government. Occupational health staff are encouraged to be alert to the opportunities to identify and report occupational health care activities that will enable others to have a better understanding of occupational health as provided in DA. Of particular interest are descriptions of new or different programs or approaches to OHS activities. Potential sources for such reporting include: Military Medicine, US Army Medical Department Mercury NEWSLETTER, the HSC Commander's Notes, the HSC Preventive Medicine Newsletter, the Reporter published by OPM, and professional medical and nursing journals. AR 360-S defines requirements for obtaining clearance to submit articles for publication or presentation at professional meetings.

CHAPTER 4

PROGRAM ADMINISTRATION

Section I. Introduction

4-1. General. This chapter contains discussions of administrative aspects of OHP management. Included are such areas as OHS organization, budgets, records and reports, facilities, use of resources, etc. Various aspects of administrative functions have been discussed earlier in relation to specific OHPs. In this section these will be described in more detail and additional administrative aspects of OHS functions will be discussed.

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Section II. Occupational Health Service Organization

4-2. Types of administrative organization. The administrative organization of the OHS will depend upon its position in the MEDDAC/MEDCEN organizational structure and the type of installation it supports. The OHS may be organized in any of the following ways:

a. A section of the PVNTMED Activity with limited or no clinic capability. Relying on the patient treatment and examination resources of the colocated MEDDAC/MEDCEN for clinical services, the occupational health section directs and coordinates implementation of the occupational health program for both civilian and military employees. It usually is staffed by one or two OHN's and a clerk. The OHN serves as the program administrator, with OHMD consultant support from PVNTMED or DPCCM. This OHS structure is found most commonly at FORSCOM and TRADOC installations.

b. An OH clinic of DPCCM with varying clinic capabilities for patient treatment and examination. The OHC chief directs and provides the OHP for civilian and military personnel. However, the OHC may use the colocated MEDDAC/MEDCEN resources for military employees' job-related treatment and examinations, as well as for various laboratory, x-ray, and other specialized services required for occupational health care or examination of civilian employees (e.g., audiometry, pulmonary function screening, etc.). The OHC is staffed usually with either a full-time or part-time OHMD, one or more OHNs, clerical staff, and ancillary staff as indicated. The PVNTMED Activity provides occupational health technical guidance and industrial hygiene support. This OHS organization is usually found at FORSCOM or TRADOC installations.

c. An OH clinic under the PVNTMED Activity with varying clinic capabilities. The functioning, use of resources, and staffing are similar to b above. Although not common, this OHS structure is found at FORSCOM, TRADOC, or HSC installations. In some instances, the Chief of PVNTMED may be a physician who also serves as the OHMD consultant.

d. An OH section of an Arm Health Clinic under the DPCCM and located at an installation separate from the MEDDAC/MEDCEN. The USAHC provides all required occupational health services for assigned military and civilian employees, with support from the MEDDAC/MEDCEN as indicated (e.g., special laboratory work, audiology consultation, etc.). Usually the occupational health program is integrated into the overall USAHC program and the entire staff is involved in the occupational health program. However, one person on the staff should be designated overall OHP manager. In addition, specific staff members may be assigned certain occupational health responsibilities (such as the hearing conservation program). The MEDDAC PVNTMED Activity provides occupational health technical guidance and the DPCCM provides administrative and professional support. This OHS organizational structure is usually found at DARCOM or DLA installations.

e. An OH nursing office under DPCCM or PVNTMED with limited capability for patient treatment and examination. Supporting medical services are provided by the MEDDAC/MEDCEN, other Federal MTF, or by local physicians, hospitals, clinics, or other community health resources under contract. It is staffed by one or two nurses, with or without a clerk. OHMD support is, at most, part-time. The range of functions will depend upon the type installation served, scope of medical direction, and OHN level of preparation or capability. These nursing offices are found in the Military District of Washington (MDW) area and at certain other small installations.

4-3. Administrative channels.

a. Regardless of the type of administrative organization, the channels of administrative and professional authority and communication must be clearly defined, provide for required coordination, and be fully understood by all concerned (AR 5-1). Each staff member must know to whom he must go when he has questions, comments, or problems related to administrative or professional (clerical, occupational health, preventive medicine, etc.) matters. The appropriate chain of command, starting at the local level within the OHS and progressing through each level until the problem is satisfactorily solved, must be used (para 4-12a and app D). Emphasis should be given to exhausting local resources first before going to higher headquarters for assistance. Requests for program support or direction should be put in writing to the greatest extent practical. The request should include necessary supporting data, and copies should be provided to all individuals or activities most concerned. Such written documentation of requests helps to clarify the requirement and expedites action on the problem. This applies to local as well as other requests.

b. Medical direction for the occupational health program is provided by the designated physician who may be a full-time civilian OHMD, a military or civilian physician with other primary duties (such as PVNTMED Officer; C, DPCCM; DPCCM staff physician; C, USAHC, etc.), or a part-time contract physician. Medical direction includes development and/or approval of medical aspects of the program (job-related medical surveillance, patient treatment, health evaluation, etc.). Paragraph 5-7 defines the overall role of the physician in more detail.

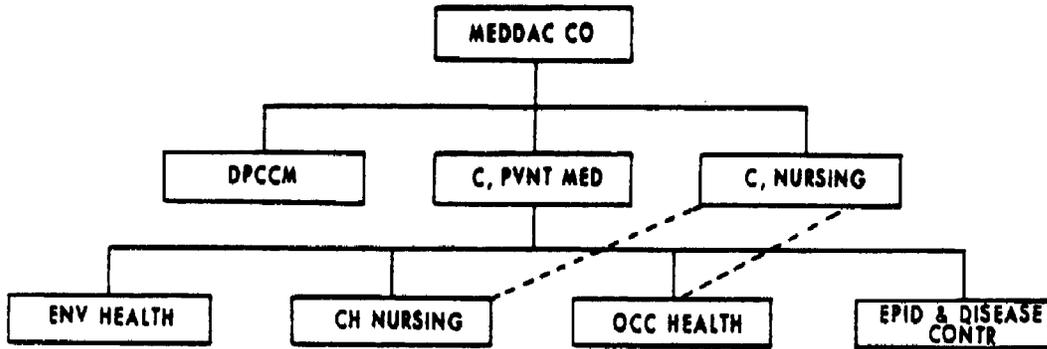
c. Under the C, PVNTMED, management and coordination of the occupational health program may be done by the OHMD if full time, or by the OHN if the physician serves on a part-time or consultant basis. In the latter case, the OHN coordinates with the OHMD or consulting physician on medical/professional matters but is responsible under the C, PVNTMED for all other aspects of program development, coordination, and implementation. At DLA installations the Safety and Health Manager (SHM) is the administrative supervisor of all safety and health activities and is responsible for program implementation. However, all professional medical decisions are the responsibility of the physician or his designee (DLAM 1000.1).

d. Organizational charts depict the lines of responsibility and authority, and the channels of communication for the OHS within the MEDDAC/MEDCEN organization.

(1) It is not practical within this manual to give examples of all possible charts applicable to all DA MACOMs, installations, and MTF. However, examples are given in HSC Reg 10-1. Usually lines of authority are

indicated by solid lines and contacts with staff advisory elements are shown by dotted lines. For example, using figure 4-1, the OHN assigned to the OH Section of the Preventive Medicine Activity does not have the authority to task personnel in the Environmental Health Section to assist her in a specific job. However, the C, PVNTMED does. Therefore, she should request assistance from the C, PVNTMED. Unless otherwise authorized, requests for assistance should go only to the person in the next higher block on the chart. Under no circumstances should this individual be bypassed to go to even higher blocks. For example, the OHN in the OH section of an Army health clinic (fig 4-2) would not go directly to the MEDDAC Commander to obtain support in solving a problem, bypassing the C. USAHC or the C. DPCCM

(2) It must be recognized, however, that purely professional matters may not follow these charts exactly. For example, in figure 4-1 the OHN and CHN are assigned to the PVNTMED Activity and, thus, do not have a direct responsibility to the Chief, Department of Nursing. However, they are responsible to the Chief, Department of Nursing for the standard of nursing care provided in their respective nursing programs and must adhere to the professional nursing policies of the Department of Nursing. It is imperative for each individual working in OH to review and utilize the organizational charts and administrative channels peculiar to his setting. He should become familiar with each resource available and utilize it. For example, a question from a USAHC relative to medical records is referred to the MEDDAC/MEDCEN and answered by personnel from the hospital patient administration (PAD) or medical records section. If the question cannot be answered at that level, it is then referred by the hospital PAD to HSC PAD. The question should not be referred directly from the USAHC to USAEHA or to HSC.



———— DIRECT AUTHORITY - - - - - TECHNICAL/ADVISORY SUPPORT

Figure 4-1. Example of a MEDDAC organizational chart (OHS section under PVNTMED)

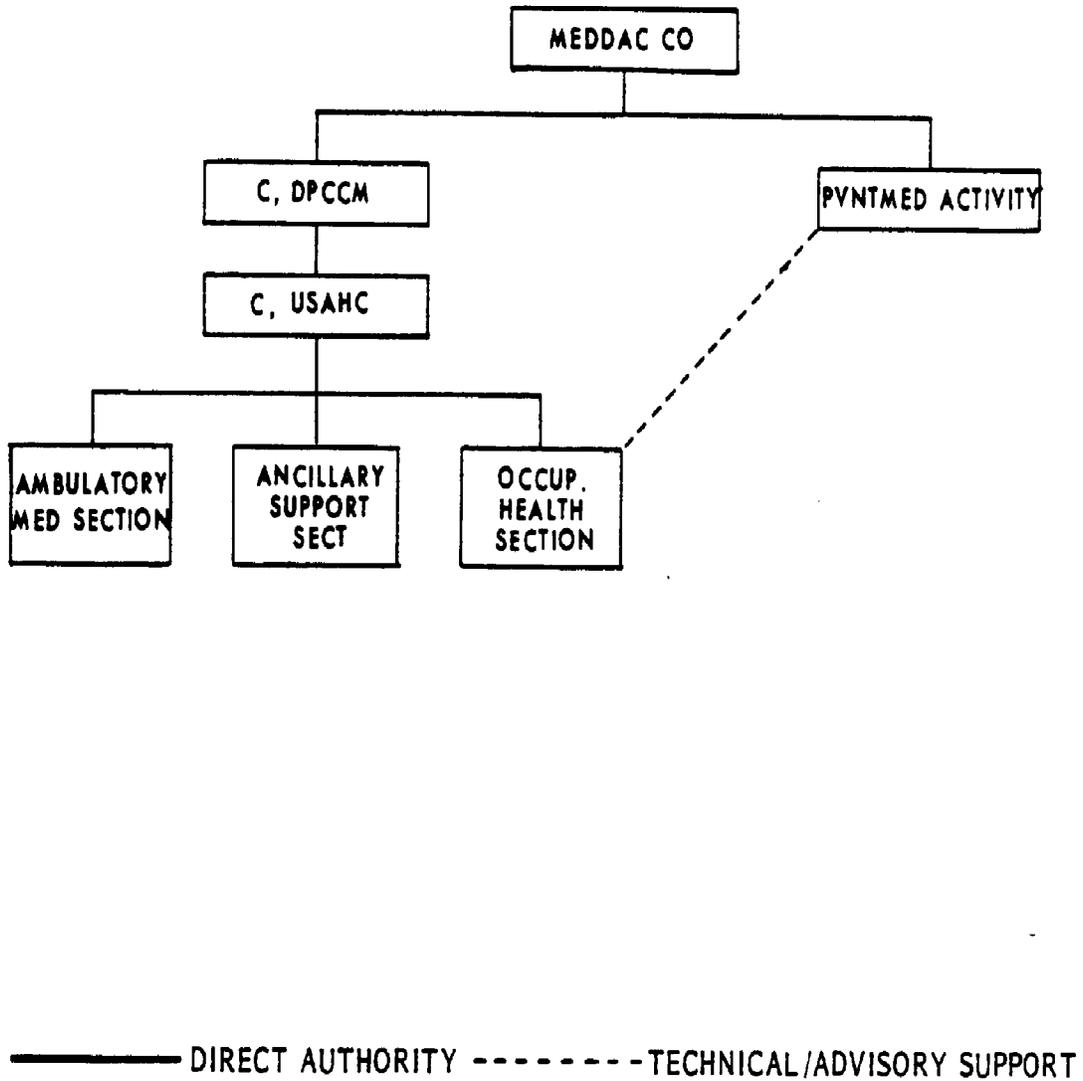


Figure 4-2. Example of a MEDDAC organizational chart (OHS of USAHC under DPCCM)

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Section III. Administrative Policies and Procedures

4-4. Administrative policies and direction.

a. General. The OHS is governed by the same DOD, DA, and OPM policies as all other Army elements. Paragraph 1-6 identifies the major laws and regulations that define occupational health policies and objectives pertinent to the OHS and the population it serves. Additional regulations and guides pertinent to administration of the OHP are listed in section I, appendix A. Local application of these policies will depend on the specific identified needs, requirements, and resources of each installation.

b. Local policies and directives. Application of Federal and MACOM policy shall be defined in local policies. These may be spelled out in installation regulations or memorandums, or in local supplements to ARs. Paragraphs 4-3 and 4-4, AR 310-2, describe these publications and define when and how they should be used. Whatever medium is used, as a minimum it should define for the local level, the scope of the program, eligibility for services, and the responsibilities of all concerned in provision or receipt of the services. The more detailed operational procedures required to implement the OHS policies should be developed separately in an SOP (d below). Whether supplement, regulation, memorandum, or SOP, the development or revision of any installation directive concerning the OHS and its programs must have the active involvement of the OHMD and/or OHN from the initial through the staffing stages. This is essential if there is to be full and appropriate use of the OHS resources. In addition, OHS staff should be continually alert to and recommend needed changes to these documents.

c. Operating program document.

(1) The MEDDAC/MEDCEN Commander is responsible for development of an annual operating program document applicable to the supported Health Services Area (AR 5-1, and HSC Regulations 11-1 and 11-4). The HSA program document provides overall direction and objectives to be used by the program managers of each MTF activity in managing their programs IAW available resources, identified priorities, and DA and HSC policy and program guidance. The OHP document is one part of the preventive medicine section of the HSA program document.

(2) The operating program document for each HSA program element (e.g., the OHP) shall state the overall program mission, list each program element, define the objectives of each element, identify priorities and/or areas to be emphasized, and describe factors or trends influencing the program. The program manager will follow this basic guidance in his management and implementation of the program.

(3) The following illustrates the type of statements that may be used in a program document developed for management of an occupational health service.

(a) The program element is : conduct a medical surveillance program for workers in health-hazardous areas.

(b) One objective for this program element may be stated : to provide the required hazard specific medical monitoring examinations each quarter to 25 percent of all personnel (civilian and military) potentially exposed at work to biological, physical, and chemical hazards.

(c) Selected actions required to achieve the objectives are :*

- The industrial hygienist will complete the LOHHI for every work location and will review and update these at least annually and whenever there are changes in the work operations. He will provide copies of ,the completed current LOHHIs to the OHMS and OHN (reference para 2-4 and 3-2a).

- The OHMS/OHN will visit each work area, at least annually, to be familiar with the work operations.

- The OHMD and/or OHN shall review the LOHHI to determine or verify medical surveillance requirements for each work group.

- OHS staff shall obtain accurate listings of all personnel potentially exposed to OH hazards in each work area and shall schedule them for the required medical surveillance examinations.

- The OHN/OHMD shall obtain a work history on each individual scheduled for a job-related examination to verify the work exposures and determine the scope of the examination.

- All personnel requiring medical surveillance shall be given the hazard specific examination at the required frequency. At least (number) examinations will be scheduled each month.

- OHS staff shall follow up on missed appointments in coordination with the supervisor and/or appropriate personnel office.

* Selected actions may apply to more than one program element or objective. For example, completion of LOHHIs is also pertinent to the health hazard identification and inventory program element.

- OHN/OHMD shall review examination findings and take action as indicated.

(d) Other objectives for the medical surveillance program may deal with such areas as epidemiological followup of abnormal findings in coordination with others concerned with administration of the medical surveillance.

(4) The objective cited in (3)(b) above is readily measured. The overall measurement would be 100 percent with interim target of accomplishing 25 percent of the required examinations each quarter. It is usually wise to set a tolerance factor (e.g., the objective of 25 percent becomes 20-30 percent of the required examinations). If program accomplishment deviates more than the 5 percent allowance in any quarter, reasons for the deviation should be identified and appropriate action taken. For example, if less than 20 percent of the examinations are performed in a quarter and the reason is that 50 percent of those scheduled were "no shows," different action would be indicated than if the reason was due to the loss of two OH staff members. Ongoing documentation, in writing, of objective accomplishment is an inherent and essential part of program management. In addition to validating accomplishments, such documentation provides timely identification of program shortcomings and problems so that prompt corrective action can be taken.

(5) Development of OHS aspects of the program document is the responsibility of the OHMD and/or OHN, but requires input from other OHS staff, as well as coordination with safety, civilian and military personnel offices, supporting MTF, and supervisors. For instance in the example above, if the medical surveillance is going to require special laboratory determinations, the laboratory service will need to be alerted and supervisors should be advised as to the proposed examination schedule to avoid any interference with their production goals. Similarly, if the objective is to provide a job-related health education program in June (in coordination with safety) for workers in the chemical laboratory, the OHS clerk may suggest that it is not possible to get the desired audiovisual aids in time for a June program, and/or the safety office may not have anyone available - due to vacations and other priorities - to assist with the program in June, or safety may state that there is a higher priority for job hazard education for the firemen instead of the chemical laboratory workers. OHS staff input to preparation of the program plan should include assistance in: identifying priorities and/or potential problems that should be included in the planning; identifying various staff capabilities, limitations and/or needs (in terms of numbers and skills and training); collecting data or information essential to program planning; and identifying methods, tools, and other resources for accomplishing program objectives. When completed, copies of the program document should be provided to all personnel who will have input in the actions required to meet the stated objectives (e.g., OHS staff, safety, personnel, PIO, etc.). Appendix G gives an example of a portion of an OH program document objectives.

d. Standing operating procedures (SOP's).

(1) The OHS SOP is as basic to the practice of occupational medicine and nursing as are the field technical manuals to the operation of the Army. In each instance, these guides provide detailed guidance for implementing, at the working level, the overall policy and regulations defined by top echelons; clearly stated instructions on how to carry out the various medical service policies and regulations; and an outline or checklist to use in the periodic review and evaluation of health service activities and facilities. The SOP gives the step-by-step procedures for performing a regularly assigned function so that the procedures may be easily understood and performed by anyone new to the function. They should be written in sufficient detail to assure continuity of operations. Such detailed guidance - readily available to the health service staff - is an important factor in the efficient, effective operation of the program. Although the need for and value of a -procedures manual is widely recognized, many occupational health services do not have such documents, or do not have a complete or up-to-date SOP manual. Instead, they rely on the broad regulations and word-of-mouth orientation from one person to another. While considerable time and effort are required to prepare and maintain an SOP, the availability of a practical SOP manual saves time in the long run. Further, one chapter or section can be developed at a time and the work load can be divided among the staff members. Perhaps one nurse who is particularly involved with health education could prepare that portion, the technicians could prepare the sections on laboratory and x-ray procedures, or clerical staff can write up the various office procedures. No matter who is involved in writing the SOP, it is the responsibility of the OHP manager to insure that comprehensive, current procedures for all aspects of the OHP are available in the OH unit.

(2) Paragraph 7-6, FM 101-5, provides guidance for development of the SOP. More specific guidance regarding format and related aspects is given in the guide, "How To Write An SOP" (app N). Other guidelines for developing the SOP are available from professional organizations. Each OHS SOP should be specific to the particular installation OHP, should cover all elements and activities of the OHP, and should reference other applicable MTF or installation SOP to avoid duplication.

(3) The development of the SOP manual begins with the definition of its purpose or objectives. Why is it needed? What use will it have? Who will use it? Each OHS must define its own SOP purpose statement specific to its own needs. When organizing the procedures within the SOP, the staff may find it practical to follow the categorical sequence of HSC Pamphlet 40-2 or other regulations. Deciding on the most efficient format and organization of SOP information may be resolved only after some experimentation. There is no one ideal pattern. Each OHS must decide what is best for that unit. What is most important is that the SOP is set up so it is useful to the staff, that it is approved by responsible officials of the OHS, and that it is kept up to date and is used by the staff.

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(4) The next step is gathering and compiling the content material which may be divided into two types.

(a) The first type material is background information such as copies of abstracts of pertinent installation and health service regulations, organization charts, record and report forms, and similar already prepared items. Sources for these will include the personnel offices, safety office, adjutant's office and the health clinic administrative files and reference shelf. While many of these items are not usually integrated into the SOP, they should be referenced in it and be readily accessible to the OHS staff.

(b) The second type of material is the OHS procedures, per se, which usually have to be written by the health clinic staff and which will require the most time and effort to prepare. The individual procedures for each OHS activity comprise the main part of the SOP in that they tell what the OHS does, and by what means and with what resources this is accomplished.

(5) A starting point for actual writing of the SOP - particularly for a busy staff - may be to set up a notebook, such as a stenographers notebook. As each staff member does or thinks of an OHS procedure or policy that should be included in the manual, jot it down in the notebook. This need not be in detail, but should include pertinent information. As the notes accumulate, they can be reviewed and divided according to categories. For example, all items related to the physical examination program would be put together. Then the writing of each section can be delegated to the various staff, as pertinent. To insure that the SOP will be a useful - and used - tool, it is important to solicit the ideas and suggestions of all concerned. This includes all health service personnel. The combined thinking of all personnel results not only in a more comprehensive SOP but also - through their involvement in its development - gives more assurance that the SOP will be used as desired.

(6) To be a viable, useful document the SOP must be reviewed and updated annually with new procedures added or old procedures changed or deleted whenever indicated. Again, suggestions of the staff should be solicited for changes needed to improve the SOP and facilitate efficient operation of the OHP.

4-5. OHS budget.

a. Budget planning, which is closely related to program planning, is essential to efficient program (and costs) management. Basically, the budget is the plan of operations and actions stated in financial terms. The degree of OHS staff involvement in the MEDDAC/MEDCEN budget planning will vary with the installation and type of OHS facility.

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b. As a minimum, and based on the operating program plan, the cost factors that OHS staff will identify as completely as possible include:

- (1) Equipment needs (new and replacement of nonexpendable/capital items, and maintenance or repair for existing items, such as bulb or plate replacements for the vision screener, etc.).
- (2) Supplies (medical and nonmedical for both routine activities and for special programs, such as for a disease screening program).
- (3) Health education materials (pamphlets, films, etc.).
- (4) OHS staff personnel costs (medical, nursing, clerical, and ancillary staff) to include fringe benefits and any anticipated overtime.
- (5) OHS staff development (reference texts and professional journals; inservice education; special skill training or other on-the-job training; education and conferences to include tuition, travel, per diem, and other TDY costs).
- (6) Other staff requirements such as relief coverage for vacations or educational leave, temporary hires for special one-time programs, contracted services, mission TDY, or additional staff needs because of expanded programs or additional OHS requirements.

c. When budget preparation is done by the DPCCM or PVNTMED Activity, the OHS staff will be sure that the above cost requirements and supporting validation are forwarded for inclusion in the budget. When the OHS staff is responsible for preparation of the budget, direction and guidance will be provided by the Comptroller. In either instance, the budget planning should include consideration not only of past cost performance, but also anticipated changes or additions to installation or medical service operations. Coordination with MEDDAC and installation staff elements is essential to efficient budget planning and facilitates mutual understanding of funding requirements and resources. For example, the laboratory service can identify its costs for specific tests and it needs to be advised when the OHS anticipates any significant changes in the number or types of tests that may be required of them for the OHP.

d. The budget also serves as a tool in evaluating cost-effectiveness aspects of the OHP. When prepared in sufficient detail, the budget can identify the OHS overall cost per employee as well as the cost of individual services and programs. Although it is generally accepted that both employees and management derive benefits from the OHP, identification of specific monetary benefits derived from OHS actions in contrast to costs of such actions is almost impossible. For example, it is difficult to define the amount of money saved by the employee and management by getting an employee under early medical care for hypertension and, supposedly, preventing more serious illness later with the related loss of productivity, sick leave, and other costs. This also applies to the OHS occupational illness and injury prevention activities, since OWCP cost data are not available per installation. However, it is good management to know the cost of running the program and, using a common sense approach, to determine as fully as possible the identifiable returns on this investment and to look for possible areas for strengthening cost controls.

4-6. Health unit planning and maintenance.

a. Facilities. Facilities should be planned in relationship to the mission and all anticipated activities of the health clinic and be IAW available funds, resources, and DA Policy.

(1) Whether considering development of a new clinic facility or improvement of existing clinic facilities, certain basic factors must be considered. The facility should be readily accessible to all workers, including new employees requiring pre-employment physical examinations, and at a safe distance from hazardous processes. Good ventilation and illumination, freedom from excessive noise, hot and cold running water, toilet facilities, and doorways wide enough for wheel chairs and stretchers are essential. Separate spaces should be provided for patient reception and waiting, treatments, examinations, rest or recovery, private counseling, medical and nursing offices, and a secure area for medical records. Laboratory, x-ray, physiotherapy, storage, and classroom areas may be needed. The amount and type of space needed will depend on the extent and type of services to be provided, the anticipated patient load, the size and type of health clinic staff, and the availability of health clinic support services such as the MEDDAC hospital resources. Hospital resources should be used as fully as possible to avoid unnecessary duplication of facilities. The layout of the facility space should be planned to assure efficient use of health clinic staff; patient comfort, safe care and privacy; separation of treatment and examination areas; and smooth and efficient traffic flow patterns for patient and staff. While not a critical factor, colors should be attractive and restful since these affect both the patient and the health clinic staff. Appendix O provides further details regarding OH clinic facility planning or assessment.

(2) When the OHS does not provide clinical services, space and facility requirements are proportionately less. However, some minimum basic factors remain the same. These include: employee accessibility, ventilation and illumination, quiet, toilet facilities, patient reception and waiting, privacy for interviewing and counseling, records and files security, and administrative and professional office space.

b. Equipment. Equipment also should be consonant with the scope of health clinic activities and the availability of other resources. Other factors to keep in mind when planning for equipment include: cost, availability within the procurement system and/or availability from other MTF resources, ease or complexity of operation, anticipated frequency of use, expected validity of results or effectiveness of operation, operator training requirements and resources, and space and related requirements (electrical outlets, etc.). Some types of equipment that can be made by installation carpenters may be more satisfactory than purchased items since they can be built to fit an existing facility. (These may or may not be more expensive than commercial items.) Requirements for emergency equipment used in the health clinic, work areas, or on emergency vehicles should be included in equipment planning. The non-clinical OHS facility should consider the need for limited medical equipment (thermometer, sphygmomanometer, stethoscope, etc.) in addition to administrative equipment. Appendix P-lists suggested OHC equipment items.

c. Supplies and medications. Supplies and medications should be limited to those that are routinely used, can be reasonably stored, or are necessary for anticipated emergency situations (app P). Disposable supplies are preferred whenever practical. The MEDDAC Centralized Materiel Service (CMS), supply, and pharmacy officers can provide guidance and assistance in determining needs, resources, and maintenance of supplies and medications, including narcotics control. Where the clinic mission is limited to OH, the medications should be limited in type and quantity to those required for emergency and palliative care.

d. Staff responsibilities. An occupational health staff person (NCOIC, OHN, clerk, etc.) should be designated the responsibility for ordering and maintaining supplies and equipment, to include assuring that stocks are adequate and up to date and equipment is in working order. The OHMD and/or OHN should assure that personnel administering medications are properly informed about the medications and their potential effect on patients. Other OH staff responsibilities related to health clinic facilities and equipment include assisting to identify and recommend requirements for new or changed facilities or equipment; coordinating with the physician and maintenance supervisors to assure that facilities and equipment are properly maintained, including prompt repairs and ongoing cleaning; and teaching and supervising staff in the proper operation of equipment. When it is not feasible for the health clinic to have particular items of equipment, such as an x-ray unit or audiometer and booth, the nurse or physician should assist in locating other facilities that can provide the service and establish a system for referrals of patients to them. So far as possible, MEDDAC/MEDCEN resources should be used first. When MEDDAC or other resources are used, they should be reasonably accessible and at a minimum cost. When it is anticipated that resources other than MEDDAC will be used on a continuing basis, consideration should be given to establishing a cross-service or contract agreement with the supplier.

e. Equipment for major emergencies. OHS staff at installations having a potential for a major emergency due to the type of activity or operation (chemical spills, explosions, etc.) or its geographical locations (tornadoes, floods, etc.) should keep these possibilities in mind when planning health unit equipment and supplies. They should also coordinate with community health care facilities to identify the type and extent of supplementary equipment and other resources that may be available.

f. Industrial hygiene equipment. Generally, industrial hygiene equipment is a PVNTMED responsibility rather than the OHS responsibility, per se. However, whether or not it is an OHS responsibility, the amount and type of equipment provided must be adequate to allow evaluation of potential hazardous exposures and controls at the installation. Questions about the technical requirements for the equipment should be referred to the PVNTMED Activity and/or USAEHA or its regional offices.

g. Reference materials. Professional reference materials, including pertinent regulations, are essential to the OHS. These include professional texts, periodicals, and related materials that provide guidance and direction for the OH staff. Sections I and II, appendix A, provide definitive lists from which to select the reference materials pertinent to the needs of the OH staff. The MEDDAC/MEDCEN reference library supplements the references maintained at the OHS.

h. Administrative and clerical supplies. Administrative and clerical supplies should include adequate amounts of official forms, file folders, etc. Periodic review of forms on hand and elimination of obsolete forms will save storage space. Paragraph 4-7 provides further guidance on records and forms.

i. Communication equipment. Communication equipment should include adequate ~ tensions dnd an intercom system. An emergency communications system, with links to fire, security, or rescue squad forces, may be highly desirable for OH clinic facilities.

4-7. OHS records and reports.

a. General.

(1) A good records and reports system is basic to effective administration of patient care and the OHP. This involves three general categories of records: cumulative individual medical records, compensation records, and administrative records and related reports.

(2) In addition to meeting OSHA and other legal requirements, OHS records "should provide data for use in job placement, establishing health standards, health maintenance, treatment and rehabilitation, workers' compensation cases, epidemiologic studies, and helping management with program evaluation and improvement."*

* Committee on Industrial Medical Records, Guide to the Development of an Industrial Medical Records System, American Medical Association, 1972, Chicago.

(3) The MTF Commander has the final responsibility for the preparation, maintenance, use, control and disposition of all medical records and reports. The C, PAD, serves as the Commander's staff officer in this area, providing assistance and guidance to the professional staff on records and reports requirements (para 1-4, AR 40-66). However, at the action level, the OHMD, if full time, or the senior OHN is primarily responsible for proper maintenance and use of the OHS medical and administrative records and reports. When OH medical records are maintained in the DPCCM records section, they are the responsibility of the Chief, DPCCM. When employees are located at an activity that has no onsite or readily accessible health care unit, the MEDDAC/MEDCEN Commander shall determine where the medical record will be maintained. In addition, each OHS staff member, professional and administrative, is responsible for accurate and complete preparation, handling, and security of records and reports. The staff should be informed about the content and use of the records and reports and should be alert to and report indications of changes or trends that suggest needed action either in patient care or health service administration. The actual handling, filing, and distribution of OHS records are a clerical function, under the direction of the OHN or medical records specialist, if one is assigned.

(4) All records and reports shall be prepared and maintained IAW recognized recording practices; professional and ethical standards; and Army (or DLA), OSHA, and OPM requirements. Pending issuance of more specific regulatory guidance for DA occupational health records, section I, appendix E lists the regulations most pertinent to the OHS records system.

(5) Standard forms are requisitioned through normal publication supply channels IAW AR 310-1. Any deviation or exception to use of standard forms must be requested and approved using DA Form 4700 (Medical Record - Supplemental Medical Data) (fig E-14) or DA Form 1167 (Request for Approval of Form) IAW paragraphs 5-4, 6-36, and 7-3 a, b, AR 40-66 and paragraphs 4-6, 4-18, 4-19, 4-25, and 4-28, AR 310-1. Recommended, or the most commonly used, standard forms for the OHS are listed in section II, appendix E. Other standard forms that may be used to meet special local needs are listed in paragraph 5-4 and 6-3, AR 40-66. Examples of selected forms are presented in section III, appendix E.

b. Individual medical records.

(1) An individual official medical folder (OMF) will be initiated and maintained for all civilian employees (AF and NAF) who are required to have preplacement and/or periodic health evaluations because of work assignments involving potential OHH or requiring specific standards of physical fitness, and/or who are provided after-hire baseline health screening. Initiation of medical folders for employees not included in the health evaluation programs should be based on the individual situation. If it is anticipated that an employee will be requiring continuing OH services that should be documented, initiation of an OMF may be medically and administratively indicated. If only incidental infrequent services are provided, these may be documented on SF 600 and filed in alphabetized folders and, on termination of employment, disposed of IAW AR 340-18-9 (AR 230-2 for NAF employees). All medical records will be maintained by the responsible medical authority. Where no OH clinic has been established, location of the OMF will depend on the local situation. It may be maintained in the OHS or in the medical records section of the MTF that is providing occupational health care services. In some instances the medical record may be kept in a separate, secured file in the servicing CPO.

(2) If an employee holds dual status as military medical care beneficiary (retired or dependent), both the his OMF and outpatient treatment record (OTR) jackets (DA Form 3444) will be clearly marked or cross-coded to identify that fact. This is necessary to assure identification and reporting by all treatment personnel of possible job-related illnesses or injuries. When indicated, summaries or copies of treatment or examination records should be included in the OMF or OTR to be sure all pertinent medical information is available to all treatment facilities. For example, when a dual status employee is treated in the Medical Clinic for hypertension, the health care provider should refer a report of that treatment to the OHS for placement in the OMF to alert the OHMD and OHN in case there is a potential relationship between the medical condition and the job assignment. Similarly, if an employee is diagnosed by the OHMD as having contact dermatitis, this information should be placed in the OTR so the MEDDAC treatment staff will be aware of a possible job relationship if future skin conditions develop.

(3) The military health record (HREC) also serves as the occupational health record for military personnel and is maintained IAW AR 40-66. In addition, military personnel with identified potential exposure to occupational health hazards (noise, toxic chemicals, radiation, etc.) who require preassignment, periodic, and/or post assignment medical surveillance will have their HREC coded or marked to show this fact. As with dual beneficiary OTR records, this is necessary to remind all treatment and examination personnel to consider job factors when diagnosing, treating, or examining these people.

(4) Record identification of potential hazards or chronic medical problems for dual beneficiaries and military personnel, as well as civilian employees may be accomplished in several ways. The codes under "Note to Physician" on DA Form 3444 (when this form is used) provide a system to identify certain job hazards or physical requirements and such medical problems as allergies. HSC Form 79 or similar medical problem record may be used in the folder in lieu of, or to supplement, the jacket coding to more fully identify the type of hazard or the medical problems. DA Label 162 (Emergency Medical Identification Symbol) (fig 4-3) should be affixed to the medical record folder when indicated (paras 5-7(3)(a) and 6-8d, AR 40-66). Some installations have developed an occupational exposure label (fig 4-4) to affix to the DA Form 3444 or HSC Form 79 to alert MTF staff treating or examining the individual.

(5) All medical records will be treated as privileged information. A copy of DD Form 2005 (Privacy Act Statement - Health Care Records) (fig E-15), signed by the patient, will be placed in each medical record (OTR, OMF, HREC). Chapter 2, AR 40-66 defines MEDDAC/MEDCEN procedures and responsibilities for protecting medical records. If an employee refuses to sign the Privacy Act Statement, the fact shall be documented that he read the statement and refused to sign it. This documentation may be made on the DD Form 2005 and/or on SF 600. Paragraph 4-1, FPM chapter 294, and paragraph 1-4, FPM chapter 339 define OPM policies and procedures for disclosure of medical information by OPM and other government agencies, to include disclosure to the public and to the civilian applicant, employee, or annuitant.

(a) Information from individual health records may be furnished to the employee's physician or any medical facility (including OPM medical authorities) upon receipt of a written authorization (DA Form 4254-R or DA Form XXXX-R) for such release signed by the employee. All requests for information from an employee health record shall be processed through the patient administrator or other individual designated by the MTF Commander.

(b) Information pertaining to a compensable or potentially compensable illness or injury of a civilian employee is the property of the OWCP and may be released to properly identified agents or representatives of OWCP [4-7c(2)]. The release of such information to OWCP should be in the form of a transcript signed by the physician in charge. It should contain no information other than that pertaining to the specific condition under investigation, and no questions should be answered which do not relate to the specific condition without the written permission of the employee.



Figure 4-3. Example of DA Label 162 (Emergency Medical Information Identification Symbol)

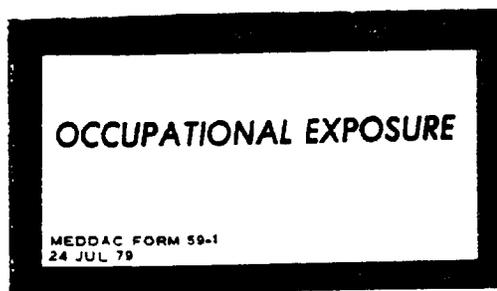


Figure 4-4. Example of occupational exposure label

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(c) When medical information or records are required by non MTF activities for legal purposes, the request shall be submitted to the MTF Commander IAW chapter 2, AR 40-66. If such a request or a subpoena is received for an employee's records that contain information regarding a compensable or potentially compensable illness or injury, OWCP should be contacted promptly for advice prior to responding.

(d) OSHA rules (29 CFR Parts 1910.20 and 1913) provide for access by the employee or his representative as designated in writing -and by OSHA representatives (compliance officers and NIOSH personnel) to examine or copy medical records or medical information that bears directly on the employee's exposure to toxic materials and harmful physical agents. Such access will be limited to the specific information required and will not include irrelevant nonexposure health information.

(e) Under the provisions of the Privacy Act, USAEHA survey officers and other personnel involved in evaluating the OHP, conducting research, performing statistical studies, etc. have access to medical records. As with other non-MTF personnel, such access is limited only to those parts of the record essential to the project at hand.

(f) When required, with the knowledge and permission of the employee, and under the direction of the physician in charge, an interpretation of medical findings may be given to the personnel officer or responsible management personnel to assure safe and effective utilization of manpower .

(6) The civilian employee medical record is initiated when the preappointment or baseline health evaluation is completed or when indicated by the employee's needs for health care services [b(1) above]. The CPO should send the OHS a monthly list of all personnel accessions or losses, to include transfers in and out. This may be used as a checklist by the OHS to be sure health records are initiated or disposed of, as indicated. The following paragraphs provide instructions for establishment of the record and use of the forms most commonly used.

(a) The OMF should be filed by the social security terminal digit number, using DA Forms 3444 (AR 40-66) when this is the approved local filing system. The terminal digit system facilitates filing of the record, including x-ray, laboratory, and related forms. When the terminal digit system has not been approved for filing OH medical records, the OMF should be placed in manila folders which may be filed by the social security terminal digit number or alphabetically by last names.

(b) The medical record jacket shall be clearly marked or coded to identify specific health problems and/or potential OHH to be considered when the individual reports for examination or treatment [b(4) above].

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(c) The medical record jacket should contain all records and information pertinent to the health care of the worker. This usually includes examination and treatment record forms, consultation reports, correspondence, and other information specific to the health of the worker. A Privacy Act Statement will be included in each health record. All data should be recorded in an organized manner; in ink, indelible pencil, or typewritten; and each entry should be dated and signed.

(d) SF 78, Certificate of Medical Examination (fig E-2) [DA Form 3437 (fig E-4) for NAF employees and SF 38 for military personnel], is used to record preplacement and other examinations and is the basic record of the OMF. The Health Qualification Placement Record portion of SF 78 (parts D, E, and F) is the only part of the form that is forwarded to the CPO appointing officer for placement purposes (FPM chap 339-4). For employees not required to have a preplacement examination, the record of the initial health evaluation on SF 600 and related forms makes up the basic OMF. This may be supplemented by SF 177 (DA Form 3666 for NAF employee) when provided by the CPO. SF 93 may be used with the initial health evaluation record on the SF 78 or the SF 600 forms to give more complete health history data.

(e) Recording of periodic medical examinations may be done on SF 78 or SF 600. SF 47 may also be used for periodic evaluation of motor vehicle operators. When used, it is usually administered and maintained by the motor pool operators licensing section. At some installations DA Form 4700 has been used to provide local forms to meet local needs for specific types of job-related health histories and examinations. At other installations overprinting of standard forms has been used. Any such variations must be approved by DA IAW paragraph 7-3, AR 40-66 and AR 310-1.

(f) SF 545 (Clinical Record - Laboratory Display) and SF 546-557 (Laboratory Test Reports) provide a chronological file for all laboratory procedures performed on the employee. This may include the Visual Performance Profile card used to record vision screening tests (fig E-8). SF 519 (Radiographic Reports) provides a chronological file for reports of x-ray examinations. SF 520 (Clinical Record - Electrocardiographic Record) is used to file results of all electrocardiograms. For certain limited examinations, the reports of test/examination results (e.g., the Visual Performance Profile or DD Form 2215, and/or a laboratory report) with appropriate notation on the SF 600, may be the only periodic examination records required.

(g) SF 600 (Chronological Record of Medical Care) (fig E-7) is used to provide a cumulative record of all health clinic visits, reason for visit, treatments, referral, health counseling, and other medical assistance given the employee for occupational or nonoccupational health conditions or problems. Each patient visit and/or treatment must be recorded in the health record in sufficient detail to facilitate followup care and provide any data required for compensation, insurance, or other administrative or legal purposes.

(h) DD Form 689 (Individual Sick Slip) (fig E-10) is used to report all occupational and nonoccupational injuries and illnesses for military and occupational injuries and illnesses for civilian employees (para 3-2, AR 335-40). It is usually brought with the patient (or sent later by the supervisor) at the time of reporting for treatment. Section II is completed by the physician, nurse, or medical technician. In addition to verifying the

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individual's eligibility for care, the DD 689 is returned to the supervisor to tell him of the disposition of the patient (e.g., returned to full duty, returned to light duty, referred to physician, etc.).

(I) SF 601 (Immunization Record) is used to record all immunizations given the employee. When required, immunization data should also be entered on the individual's Public Health Service Form 731 (International Certificate of Vaccination).

(j) DD Form 1141 (Record of Occupational exposure to Ionizing Radiation) (fig E-9), will be used in accordance with AR 40-14 for each person who is potentially or routinely exposed to ionizing radiation to record all film badge readings. [DD Form 1952 (Film Badge Application and Record of Exposure) is used to start an employee on the local film badge program and to obtain a record of previous occupational exposure to ionizing radiation IAW AR 40-14. DD Form 1952 is initiated and maintained by the RPO.]

(k) SF 513 (Consultation Sheet) (fig E-16) is used to obtain and record the opinion of a consultant regarding a specific health problem of an employee. The reason for the request should be clearly stated with appropriate background information.

(l) Office of Personnel Management Forms [CCS Form 4434 (Medical Report, Pulmonary Tuberculosis); CSC Form 3684 (Medical Report, Diabetes Mellitus); and SF 739 (Medical Report, Epilepsy)] may be used to obtain the report and opinion of the private physician regarding the employability of applicants who have a history of tuberculosis, epilepsy, or diabetes. Generally, these forms are used by CPO to determine an applicant's capability to perform a job (para S1-3 and app A, FPM Supplement 339-31), but may also be used after hire to obtain specific data about an employee's medical problem.

(m) DA Form 3365 (Authorization for Medical Warning Tag) (AR 40-15), is used to obtain and record the information necessary to provide military or civilian personnel with medical warning tags. When these tags are issued, DA Label 162. should be affixed to the DA Form 3444 [b(4) above].

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(n) DA Form 4515 (Personnel Reliability Program Record Identifier) and DA Forms 3180 and 3180A (Personnel Screening and Evaluation Records) are used IAW AR 50-5 and AR 50-6 to identify and evaluate all individuals working in the nuclear or chemical surety programs. Medical responsibilities for initial and periodic screening of these individuals is contained in the above regulations .

(o) DD Form 2214, DO Form 2215, OO Form 2216, and DD Form 2217 are the forms used to support the hearing conservation program (para 3-3f(1)). Detailed guidance for their preparation and use is contained in TB MED) 501.

(7) On notification by the CPO that an employee is transferring to another Federal agency, the medical record shall be screened and all temporary (e.g., correspondence of short term interest, etc.) material deleted. The record is then sent in a sealed envelope to the CPO to be forwarded with the OPF to the receiving agency.

(8) On notification by the CPO that a civilian employee has terminated Federal employment, the medical record is screened and all temporary or extraneous material is deleted. The medical examination certificates of preplacement, fitness for duty, and disability retirement examinations are placed in a sealed envelope and sent to the CPO for disposition with the OPF. The remainder of the medical record is placed in the inactive medical record file upon separation and disposed of IAW AR 340-18-9 by the MTF. All medical record data potentially pertinent to the individual's work assignment and/or potentially hazardous exposures must be retained for 30 years after termination IAW OSHA and DOD guidance.

(9) Preplacement examination records (SF 78) of applicants who are not hired should be returned to the CPO for filing and disposition with the OPF. Paragraphs 3-2 e and f, FPM 339, define the procedure to follow if the individual is not medically qualified for the position.

c. Office of Workers' Compensation Programs records and procedures (FPM 810).

(1) The Federal Employees' Compensation Act (FECA) authorizes the OWCP, Department of Labor, to conduct the program that provides certain benefits, including medical care, necessary for job-related injuries for appropriated fund employees. The term "injury" includes, besides traumatic injury, any disease or illness caused or aggravated by the work assignment. Medical care may be provided by a United States Government medical officer or MTF or by any duly qualified physician or hospital of the worker's choice. The act defines "physician" to include surgeons, podiatrists, clinical psychologists, optometrists, and osteopathic practitioners within the scope of their practice as defined by State law. Chiropractors are also included but only for diagnosis and manual treatment for a subluxation of the spine.

(2) All records, medical and other reports, relating to the injury or death of an employee entitled to FECA benefits are the official records of OWCP and are not the records of any agency having the care or use of such records. Information from or about these records may not be released without written approval from OWCP. Supervisors are responsible to maintain an adequate supply of the basic forms required [OWCP Pam CA-136 (Federal Employees Compensation Act Basic Forms)]. The CPO is responsible for processing and forwarding to OWCP all compensation claims and records. Copies of medical aspects of these records, when treatment is provided by the DA MTF, may be placed in the individual health record in addition to the data recorded on SF 600 and other MTF medical forms.

(3) OWCP Pamphlet CA-136 lists the basic forms required to report job-related injury or illness and to request and record medical treatment, as well as to meet other OWCP administrative requirements. The pamphlet also outlines the purpose of each form, who is responsible for its preparation, when it must be submitted and to whom. FPM 810 gives more detailed instructions for handling the records and other aspects of workers' compensation claims.

(4) OWCP reimbursement claims forms (e.g., CA-15) will not be used for reimbursement to the Federal MTF when only emergency diagnosis and first aid treatment are required by or given to civilian employees by the MTF. Paragraphs 4-20, 4-21, and 4-31, AR 40-3, define the circumstances when OWCP reimbursement claims by Army MTF shall be made. Paragraph 4-31, AR 40-3, also gives direction for use and disposition of Form CA-16 when definitive medical diagnosis and treatment (beyond first aid) of occupational injury are given by the OH Clinic or other Army MTF. When any OWCP forms are completed for a patient by the MTF, this fact (with the date and distribution of the form) should be noted on SF 600 in the health record along with all pertinent information regarding the injury (date, time, place, circumstances, type and site of injury, treatment given, recommendations, and referral or disposition made).

d. Nonappropriated Fund employees' workers' compensation.

(1) The Nonappropriated Fund Instrumentalities (NAFI) Act of 18 November 1953 provides workers' compensation coverage for NAFI employees under the Longshoremen's and Harbor Workers' Compensation Act. Coverage is provided under a commercial insurer's workers' compensation policy procured, held, and administered by the Army Central Insurance Fund (ACIF). Medical care and services provided under the policy are similar to those provided AF employees under OWCP. However, DA MTF responsibilities are limited to initial and emergency care, provided without charge, with referral to community medical resources when further medical care is indicated.

(2) Records and reports required for NAFI employees incurring occupational illnesses or injuries are defined in chapter 13, AR 230-16. This includes directions on when and how the forms are to be initiated. The NAFI custodian is responsible for proper management of the NAFI workers compensation program.

e. Administrative records and reports . These are the media used to facilitate the day to day operation of the OHS and to collect and reflect statistical, epidemiological, and other information about occupational health programs and activities.

(1) The most commonly used standard medical administrative record and report forms and the related regulations are listed in sections I and II, appendix E. Administrative forms are also governed by AR 40-66 and Privacy Act requirements.

(2) Development of any local administrative record and report forms should be restricted to only when no other available form will meet the local need, with or without adaptation. Chapter 4, AR 310-1 gives the procedure for developing new forms or for over printing standard forms. These should be coordinated with the Chief, PAD and the Forms Management Office. Any forms which will identify patients by name and/or social security number (such as suspense files or daily log sheets) must conform with Privacy Act requirements .

(3) The embossed Patient Recording Card (para 3-2a, AR 40-66) should be used to the greatest extent possible for all medical records (civilian and military) . This promotes both efficiency and accuracy of recording patient identification data on medical records, including laboratory and x-ray requests. It can also serve to verify the employee's eligibility for care.

(4) Several forms are available for obtaining medical data about employees from other health care facilities or resources. These include DA Form 4254R (Request for Private Medical Information), DA Form XXXX-R (Authorization for Disclosure of Information), and DD Form 877 (Request for Medical/Dental Records or Information). Both DA Form 4254-R and DD Form 877 must be accompanied by the employee's written authorization for release of the requested information. AR 40-66 provides direction for use of these forms.

(5) Any clinic that has controlled substances on hand must maintain an inventory [DA Form 3949-1 (Controlled Substances Inventory) (fig E-17)] and record [DA Form 3949 (Controlled Substances Record) (fig E-18)] for these items. AR 40-2 and TB MED 291 give directions for establishing and maintaining these records.

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(6) In addition to the medically-oriented administrative records cited above, the OHS will use such other forms as may be required for supply procurement, maintenance, and accounting; OHS personnel actions; and budget and OHS administration. Guidance in use of these forms should be available from local supply, personnel, and related MEDDAC or installation staff, as well as in regulations.

(7) The MTF has responsibility for submitting several recurring reports which require OH input. The Chief, PAD is responsible for establishing procedures to obtain data for all required reports. The OHS Chief shall coordinate with PAD to identify and be sure that all occupational health reporting requirements are met. While the OHS staff may or may not actually compile these periodic reports, they should know what data related to the OHS are required for the reports. This includes knowing both the quantitative and qualitative OHS accomplishments, trends in activities and health service needs, the relation of services given to the anticipated needs for such services, and reasons and plans for change. In addition to recurring reports, the OHS may be involved in special projects or studies where the staff will be responsible for collecting and organizing data to show the effectiveness or results of the program. the primary recurring reports requiring occupational health input include:

(a) Army Occupational Health Report [MED 20 (R3), DA Form 30763 (fig E-13) (DLA Form 1013) is used to report semiannually on the OHP of each installation. The data from these reports are used by USAEHA to prepare an annual summary report, The Army Occupational Health Program, of the overall Army OHP Even more important than its use by higher headquarters, the completed report provides a useful tool for local evaluation of the OHP [para 3-13b(1)]. Instructions for completing the report are found in AR 40-5. Data collection for the report requires a coordinated system whereby all personnel involved clearly understand what data are required and how they are to be used. DA Form 3075, Occupational Health Daily Log (fig E-19) is used for the on-going recording of the required data. [DLA Form 1012, Log of Occupational Health Services, is used to collect the data for DLA Form 1013 (DLAM 1000.1)]. Each installation must devise its own systems to insure required data are recorded daily by each MTF activity providing OH services. These data are then collected by the report coordinator who will use them to prepare a monthly data summary to be used later in preparing the semiannual report.

(b) The monthly Medical Summary Report [MED 302 (R2), DA 2789-R] is a management report of selected types of medical care (including occupational health) furnished by the MTF. The data are used for budget and program planning, manpower actions, and other related purposes. In addition to AR 40-418 instructions, AR 40-62 further defines how to count the services included in this report.

(c) The Command Health Report (AR 40-5) is used to provide commanders and others with information regarding health conditions within a command, to report recommendations for or actions taken to improve conditions or conserve manpower, and to advise higher headquarters of support needed to implement recommended actions. This includes reporting of occupational health conditions, recommendations, actions, or support requirements. More specifically, this report should be used to report special, unusual, or urgent problems or actions - not the routine information for which other reporting channels are available.

(d) The MEDDAC Annual Historical Report [MED 41 (R4), AR 40-226] provides a summary record of major occurrences, accomplishments, activities, and problem areas of the MEDDAC. The OH portion will be included under that of the PMA. Data required for this should be identified and appropriate records kept throughout the year to be sure the OH report is complete and descriptive of the program accomplishments.

(e) The Occupational Safety and Health Act of 1970 contains certain recordkeeping requirements. Instructions for maintaining these records are contained in chapter 4, AR 385-40, and in "Recordkeeping Requirements, U. S. Department of Labor, Occupational Safety and Health Administration" (OSHA). Figure 4-5, OSHA Guide to Recordability, defines those civilian occupational illness and injury cases that must be recorded for OSHA purposes. Definitions of the classes of reportable injuries and illnesses are found in appendix C. Although the safety officer has primary responsibility for these reports, the occupational health staff and/or other MTF treatment staff must provide the basic data as these relate to medical aspects of occupational injuries or illnesses. OSHA Form 100F (Log of Federal Occupational Injuries and Illnesses) (fig E-20) is used to maintain the data for all recordable occupational injuries and illnesses and it is the feeder report for OSHA Form 102F (Summary Report of Federal Occupational Injuries and Illnesses). The data on these reports should conform with the Injury and Illness data of DA 3076. Therefore, close coordination by safety and OHS staffs is essential in both collecting, recording, and reporting the data.

(f) Brief narrative reports may be written at monthly or quarterly intervals identifying primary activities or specific problems or accomplishments occurring during the report period. This may include brief summaries of epidemiological investigations of hazard over exposures, results of screening programs, OH staff community activities related to OH (e.g., OH orientation of student groups), and training activities by or for OH staff, etc. Copies of these reports, when submitted to individuals such as C, PVNTMED; C, Safety; C, Nursing Service; C, CPO and MILPO; and MEDDAC and Installation Commanders will help increase their awareness of and familiarity with the OHP.

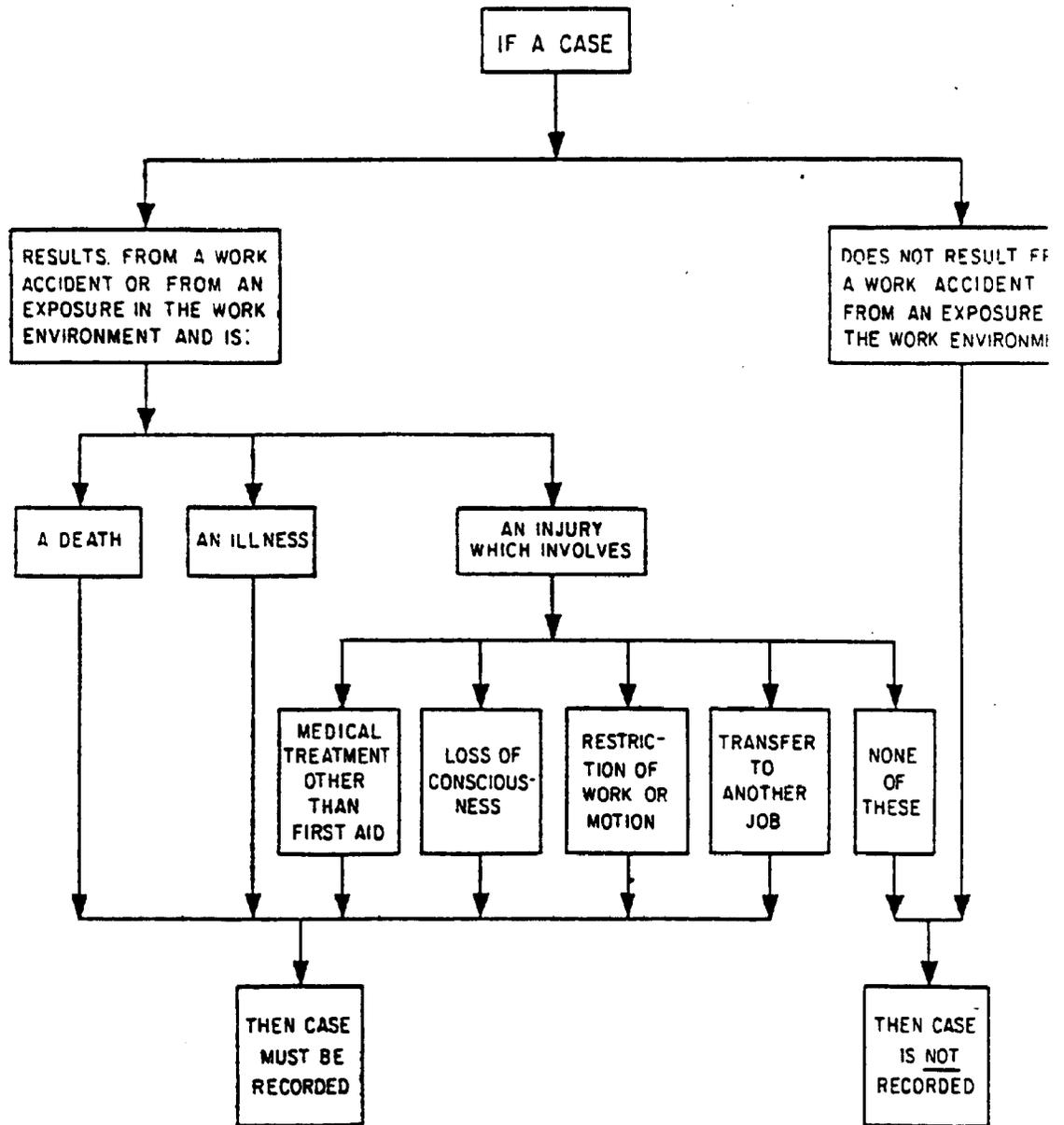


Figure 4-5. OSHA guide to recordability

f. Automatic data processing. AR 18-1 provides guidance for the use of ADP resources. The installation MISO, CPO, MILPO, Comptroller, and Chief, PAD can identify ADP resources currently available at the installation that may be used to support the OHP. This support may range from giving basic statistics on the population served to scheduling routine examinations to recording and processing data for special preventive programs or for epidemiologic studies. OHS personnel wanting to use available ADP resources must clearly define what data are wanted, how they will be used, and why. The ADP personnel can then advise whether or not they can provide the support within the capability of their equipment and staff. New programs or systems require HSC and/or OTSG approval.

4-8. Use of Resources.

a. General. Each OHS has various resources that should be identified and used to supplement or complement the OHS capabilities. Medical resources were described in paragraph 2-14, throughout section II, chapter 3 and are further defined in paragraph b below. Other major resources are those available within the installation command and within the community. A list of the primary OHS resources should be included in the SOP. This listing should identify each facility, what services it can provide (and any restrictions or special instructions for its use), the primary contact person, and the address and phone number. In addition, the SOP should clearly define the administrative and professional channels to be followed when working with each resource. The OHS should establish a contact with each potential support activity (on and off post); explore areas of mutual concern with each; and develop a system(s) to insure continuing communication and coordination to make full use of available services and avoid duplication of effort. The details of when and how to obtain each of the most commonly used resources should be included in the SOP. This includes special consultants, such as referrals for compensation cases; ambulance service; hospital, laboratory, x-ray, and related patient care services; public health nursing and home care agencies; and other installation or community resources. All OHS staff should be familiar with these resources and encourage their use by the health clinic and employees when indicated.

b. MEDDAC/MEDCEN resources. Various medical resources and their relationship to the OHS program are identified in other sections of the manual and/or in HSC Regulation 10-1. Some of the personnel with whom the OHS staff works most frequently are:

(1) The *Chief, Preventive Medicine Activity* is responsible for providing overall OHP guidance and prescribing preventive aspects of the OHP. The C, PMA frequently serves as MEDDAC representative on a variety of installation committees (Planning and Review Board, Safety Committee, etc.) and thus provides liaison for the OHS with these activities as well as with installation command and tenants. When the OHS is a section of PMA, the C, PMA is the primary channel for communications with the other MEDDAC activities providing OH services. When the OHS is a clinic under DPCCM, the C, PMA provides consultation and guidance for OHP content and development. The C, PMA, who may be a physician, CHN, ESO, or veterinarian, will also provide consultant support in his specific area of expertise.

(2) The *Environmental Science Officer and/or industrial hygienist* (or technician) is a member of the OH team, but is usually assigned to the Environmental Health Branch of PMA rather than the OH staff. He conducts the industrial hygiene surveys, maintains the health hazard inventory, makes special investigations of potential health hazard problems, and maintains liaison with installation safety and other personnel relative to control of health and safety hazards. He also assists with provision of job-related health education of military and civilian employees. He should be a primary contact when the OHMD or OHN have questions regarding exposures of employees. The industrial hygienist's functions are outlined more fully in paragraph 5-11.

(3) The *audiologist* is a member of the OH team, but is usually assigned to the ENT Clinic. He provides overall guidance and technical direction for the hearing conservation program and serves as consultant to the OHS staff on hearing conservation matters. The audiologist's functions are described in more detail in paragraph 5-20.

(4) The *Community Health Nurse* may provide consultation and assistance in public health nursing matters, coordination with local community health resources, coordination and followup of dual status beneficiaries with health problems related to their work assignments, and coordination in provision of health screening and health education programs for military and civilian employees. The CHN, as a member of the military, - also may assist to clarify military procedures and regulations for civilian OHN staff members.

(5) The *Chief, DPCCM* responsibilities for occupational health will depend on the type and organization of the OHS. When the OHS is a section of PMA and has no clinic functions, the C, DPCCM provides all clinical support services (physical examination, treatment of illness and injury, laboratory and other medical tests, etc.) and may serve as OH medical consultant to the OHN. When the OHS is a clinic facility under DPCCM, the C, DPCCM provides administrative and professional direction of the clinic, coordination with other DPCCM supporting activities, and relies on C, PMA for OHP technical guidance.

(6) The *Chief, Department of Nursing*, is responsible for the technical aspects of all nursing activities within the MEDDAC/MEDCEN. She provides direction, consultation, and support in defining nursing functions and standards of nursing practice and in evaluation of nursing performance through nursing audits or quality assurance activities. This nursing leadership and support is available to and should be used by all nurses within the MEDDAC/MEDCEN. Active liaison by the OHN with the Chief, Department of Nursing also facilitates coordination of OH services for hospital nursing staff.

(7) The *Chief, PAD*, responsibilities pertinent to the OHS include technical assistance in the management of medical records, coordination of medical statistical reporting, and release or transmittal of requested medical records or information.

(8) The *hospital infections control officer* is responsible for the prevention and control of all hospital-associated infections as this relates both to patients and employees. Paragraph 3-6 describes the areas of coordinated OHS/hospital infection control activities.

(9) The *flight surgeon* is responsible for the medical care and required examinations of all military personnel in flight status and for medical investigation of all aircraft accidents. OHS coordination with the flight surgeon should include exchange of information concerning nonflight-related OH requirements, OH injury and illness incidence data, and other data required for the Army Occupational Health Report (DA form 3076), such as number and types of examinations provided by the flight surgeon. Occasionally, the flight surgeon has been given the additional duty as the designated OHMD or OHMD consultant.

c. Installation resources. Some of the major or most frequently used installation resources are described below.

(1) *Command support* is essential to the success of any program. Occupational health is no exception. This requires the OHS to keep the Commander informed about the OHS Program (ongoing or special activities) as to its purpose; requirements (versus nice-to-have); costs (to him) in terms of money and employee time (military and civilian); and anticipated benefits, particularly as these lay affect him and his staff in accomplishing his mission, whether or not a program is implemented and/or successful. This may be accomplished through periodic briefings and/Gr summary reports of overall OHS programs or of specific OH problems or programs, reports to the safety committee, and through other local reporting media. In all dealings with the installation CO, it is important to remember that a major objective of the OHS is to support the Commander in his mission accomplishment. Examples of informed Commander's support which has been provided at some installations include changes to local regulations to require compliance with certain OHPs, taped Commander's briefing for troops to emphasize compliance with a particular program, and temporary loan of installation or Division personnel to the MTF for a special program or until the MTF could supplement its own staff.

(2) The support of *managers and supervisors* (military and civilian) at all levels is also important to the OHS mission. As with the Commander, a demonstrated awareness that the OHS is supportive to the supervisor or Company Commander, namely to keep his workers healthy and able to work, fosters a cooperative relationship with the supervisor. Major areas of supervisor support or cooperative actions include:

(a) Exchange of information about OHH in the work area includes provision of information by the supervisor about new processes or products that may present health problems and OHS information to the supervisor about health aspects of hazards and how to prevent or control adverse reactions.

(b) Training of employees in health and safety protective measures is primarily the supervisors responsibility. To do this, he needs the guidance and support of the OHS on health aspects. For example, OHS staff may give special training to supervisors concerning specific hazards so they may brief their workers. Or, the OHS staff may assist the supervisor with his onsite health/safety briefings or meetings with workers.

(c) Enforcement of proper use and maintenance of personal protective equipment is encouraged by the supervisor's and OH staff's personal example and instruction.

(d) Prompt referral, with necessary documents, of employees for treatment of injuries or illnesses. The OHS should be sure supervisors are promptly informed regarding disposition of the patient, as well as any changes in referral procedures, etc.

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(e) Coordinating with the personnel offices and the OHS to insure that job-related medical surveillance of employees is accomplished on a timely basis.

(f) Prompt referral of pregnant employees to the OHS (or OB Clinic) for evaluation in relation to work assignment.

(g) Referral of civilian employees to the OHS for clearance or treatment before leaving work during duty hours for reasons of illness and for clearance before return to work after sickness absence of 5 or 10 . workdays (depending on local policy).

(h) Advising the OHS about any employees with medical problems that may benefit from coordination of the OHS with their personal physician, such as identification of OHS resources that might speed up the employees rehabilitation and/or return to duty.

(3) The CPO supports the OHS both in civilian employee management aspects of the OHP and in OHS staff personnel actions (FPM 250, 290, 293, 294, 296, 339, 410, 792; Civilian Personnel Regulation M-1).

(a) IAW FPM 250 the CPO is responsible to assist the Commander, program managers, and firstline supervisors to carry out their personnel management responsibilities, including health protection of the employee. The CPO also is responsible for the development and use of an up-to-date manpower information system to facilitate effective selection and use of available manpower. More specifically, CPO services or actions of importance to OHS program management include, but are not limited to:

- Referring applicants for preplacement physical evaluations.
- Inprocessing all new employees through the OHS for orientation, and for baseline health evaluation when indicated.
- Providing the OHS with periodic (monthly) listing of all personnel accessions, transfers, and losses.
- Coordinating with the OHMD and the Safety Office to identify all physical stress positions.
- Scheduling employees for periodic job-related medical surveillance, in coordination with supervisors.
- Providing the OHS with adequate supportive data for employees being referred for fitness-for-duty health evaluations.

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- Providing labor management expertise and liaison with unions, including handling and coordination of grievance procedures that may be related to the OHS.
 - Processing workers' compensation claims.
 - Coordinating with OHS staff (and Safety when indicated) to provide supervisors and employees with orientation and training relative to the OHS programs, health aspects of job hazards. and general health maintenance.
 - Providing guidance and support to supervisors in enforcement of proper use and maintenance of personal protective equipment by employees.
 - Arranging for proper replacement of employees temporarily or permanently physically disqualified for their jobs.
 - Providing statistical and related personnel data required by the OHS, including advance notice of any significant projected changes in population served.
 - Establishing a policy and procedure for referral of pregnant employees to the OHS for initial evaluation in regard to the work assignment.
 - Coordinating with the OHS to establish a policy for referral of employees to the OHS for clearance or treatment before leaving work during duty hours and for clearance before return to work after sickness absences of 5 or 10 working days.
- (b) The extent of CPO staff support for OHS staff personnel actions will depend on the local situation. Generally, these include:
- Coordination with the Chief, OHS or other responsible MTF person to prepare OHS staff job descriptions, classification, and standards of performance.
 - Implementation or assistance with job actions related to employee - recruitment, training, work performance evaluation, promotion, transfer, termination, leave, awards, discipline, etc.
- (4) MILPO has a responsibility for military employees similar to that of the CPO for civilian employees. The MILPO supports the management aspects of the OHP and MTF military-staff personnel actions IAW AR 600-8. Primary areas for coordination and communication of the OHS with the MILPO include:

(a) Development of a system to insure that newly assigned military have appropriate, current baseline health data in relation to their job assignment (e.g. a baseline pulmonary function test if they will be required to wear respirators) and/or to identify those who will be requiring specific periodic job-related medical surveillance in addition to their routine age-related physical examinations. For example, at several installations the TMC or other MTF receiving the health records of inprocessing military are screening the records and giving the OHS the names and other pertinent information of military personnel to be included in the job-related medical surveillance program. Training of TMC staff in this screening and selection process is given by the OHS staff.

(b) Scheduling military personnel for required periodic and termination job-related medical surveillance. DA Pamphlet 600-3, procedure 5--18, Medical Examinations, gives the step by step procedure for scheduling required medical examinations for military personnel. This procedure will need to be modified IAW local capabilities for the limited or special job-related examinations. Such modification requires coordinated effort by MILPO, OHS and appropriate unit or other military Commanders.

(c) Coordination with OHS and safety to provide military personnel with occupational health and safety education to include health aspects of job hazards.

(d) Providing statistical and related personnel data required by the OHS.

(e) Establishing a policy to assure early referral of pregnant military employees to the OHS, OB Clinic, or CHN for initial evaluation in regard to the duty assignment.

(5) The *safety office* and the OHS are mutually supportive in implementing the DA occupational health and safety program. Safety responsibilities and procedures are defined in the AR 385 series, with AR 385-10, 385-32, and 385-40 being most pertinent to OHS interests. The safety officer's functions are summarized in paragraph 5-23. To avoid duplication of effort in areas that may overlap, close coordination and cooperation is required between safety, the OHS, and industrial hygiene (PVNTMED). The most common areas of support and/or coordination include:

(a) Identification of hazardous areas/jobs and required protective equipment and other controls. While some safety offices may have industrial hygiene capabilities, industrial hygiene is a PVNTMED responsibility to include maintenance of the hazard inventory. In particular, safety provides tile data on eye hazardous jobs and physical stress positions in addition to their identification and control of mechanical, electrical, and fire hazards. The OHS staff should refer suspected potential safety problems or questions to safety and/or supervisors. For example, the OHS staff may notice an increased incidence of a particular complaint (foreign body in the eye, finger lacerations) from one or more departments. Early referral of such information will help the safety officer and supervisor take corrective action before the problem becomes more serious.

(b) Instructions for and enforcement of safe work measures, including use of protective equipment. This involves coordination in assisting supervisors with their responsibilities in this area both through training and onsite observation and counseling. For example, when visiting worksites, both safety and occupational health staff should know what personal protective equipment is needed, should observe if it is being used properly, and should coordinate with the supervisor in advising the employee when the protective equipment is not being properly selected, not used, or is being used improperly.

(c) Injury and illness reporting and investigation. The Safety Officer is responsible for DA and OSHA job-related injury and illness (civilian and military) reporting and for investigating all accidents. The OHS is responsible for the DA Occupational Health Report and for investigating occupational illnesses to include investigation/verification of the occupational exposure by the industrial hygienist. A coordinated system must be developed by Safety and OHS (and other concerned MTF staff) to assure all occupational injuries and illnesses are promptly reported to all concerned and are investigated as necessary to identify causes and prevent recurrences. This should include an exchange of injury and illness statistical data by Safety and the OHS.

(d) Coordination of the installation occupational safety and health committee. The OHS should be represented on the committee to present or advise about health aspects of any job-related safety or health problems discussed, to keep informed about safety and health problems of the installation, and to advise about the availability and/or capability of health resources that may be wanted or needed. This committee also may be used as another means for presenting occupational health problems or needs to the Commander and other key installation staff. Where the MEDDAC CO; Chief, PVNTMED; or similar non-OHS individual is the official MEDDAC representative on the committee, consideration should be given to having the OHMD or OHN sit in as ex-officio committee members, particularly when OHS related matters are to be discussed.

(6) The *division surgeon* potential installation OHS resource. He, or his PVNTMED officer, is the primary contact for OHS coordination of the OHP for personnel assigned to the Division. The FORSCOM/TRADOC/HSC MOU defines when and how Division medical personnel may be utilized to support the MEDDAC/MEDCEN. Occasionally, depending on their staffing and mission requirements, Division Surgeons have provided temporary OHS or PVNTMED staffing assistance to help with special programs or projects. In several instances arrangements have been made by the OHS and audiology to have all hearing testing for division troops performed by the division AMEDD TOE personnel. The OHS shall establish an ongoing coordination with the Division Surgeon and PVNTMED officer to keep them informed about occupational health requirements, to provide guidance and assistance with identification and control of specific hazards, and to make full use of all available resources.

(7) *Installation directorates* and offices provide a variety of -resources to the OHS from different installation activities. The actual source may vary IAW the installation organization. To identify these sources and primary contacts, a copy of the current installation organizational chart should be readily accessible in each OHS. Some examples of these resources are:

(a) The *Plans, Operations, and Training Directorate*, among other functions, identifies all physical facilities on post and if and how (type operations) they are being used, is responsible for emergency planning, and coordinates installation educational and audiovisual training services.

(b) Computer resources to facilitate maintenance of the hazard inventory and the job-related medical surveillance schedule may be available from the *Management Information Systems Office*. Listings or printouts of installation personnel and or other selected population statistical data may be available from MISO, CPO, MILPO, or the Comptroller.

(c) The *Public Affairs Office* or Public Information Office assists with preparation and publication or distribution of articles, notices of routine or special programs, and other types of publicity.

(d) At several installations the OHS has found it very helpful to have someone designated as *occupational health and safety coordinator* for each major activity. These individuals facilitate scheduling of occupational health services for people assigned to the respective activities, provide the activities with information about the OHS, and can answer their coworkers questions or readily refer them to the OHS.

(8) *Union representatives* can provide valuable OHS support when they are consulted with and/or kept informed about the purpose and anticipated results or effects of ongoing or special programs. Frequently, employee complaints, problems, or fears can be resolved before they become blown out of proportion when an effective cooperative relationship has been established by the OH staff with union representatives. This includes keeping the OHS advised about potential occupational health problems and encouraging employees to comply with OHS programs.

d. Community resources.

(1) Depending on the location, a variety of community resources are available for patient referral or to supplement OHS services. In many communities a directory of community health and welfare resources is published. Under the National Health Planning and Resources Development Act of 1974 (PL 93-641), local Health Systems Agency planning groups will collect data about all community health resources. These directories or data collections usually identify the resource, the purpose and services offered, key personnel and how to contact them. These data should be kept in the OHS and made available to employees as needed. In addition, when special community health programs are set up within the community (e.g., a vision screening program for preschoolers, a diabetic screening program, a cancer detection or education activity, etc.), the OHS should arrange publicity for them in post bulletins or other publications.

(2) The community health resources most commonly used by the OHS or employees include:

(a) *Local physicians*, both specialized consultants and employees' personal physicians.

(b) *Health care facilities*, such as hospitals, clinics, laboratories, and ambulance services.

(c) *Official and voluntary health agencies* such as local, State and Federal health departments, the American Heart Association, Society for Prevention of Blindness, the American Cancer Society, and The Lung Association. This includes volunteers of the American National Red Cross.

(d) *Local or regional offices of Federal agencies* that include occupational health as a major function or concern, such as OPM regional occupational health representatives, Department of Labor OSHA offices, and OWCP.

(e) *Professional organizations* such as the American Medical Association, American Association of Occupational Health Nurses, American Occupational Medical Association, American Optometric Association, and American Public Health Association.

(f) *Colleges and universities.*

(g) *Insurance and drug companies.*

(h) *Service organizations* (Lion's Club, Optimists, Chamber of Commerce) that support health oriented projects.

(3) The type or extent of services provided by these community resources will vary IAW their objectives, organization and staffing, and the needs of the area. In general, the services of most value to the OHS and employees include:

(a) Definitive diagnosis and treatment of individual workers and/or emergency transportation and care.

(b) Specialized laboratory or other test procedures not available through the MEDDAC or other DA resources.

(c) Patient counseling services for employees' personal or family health or related problems.

(d) Provision of employee health education materials and programs on or off post.

(e) Provision of disease screening programs on or off post.

(f) Provision of home health care or homemaker services.

(g) Provision of professional education programs and conferences in occupational health or related fields.

(4) OHS staff functions aimed at making optimum use of community resources include:

(a) Visit agencies to establish liaison and become familiar with facilities, personnel, and services.

(b) Assist employees with referrals and provide followup as indicated. This may include communicating with physicians or health agencies and the employee's family to coordinate use of resources, as well as counseling the employee to be sure he understands and is able to follow the health care plan.

(c) Coordinate with health agencies to promote and assist with planning, implementation, and followup of disease screening or health education programs both on and off post.

(d) Interpret to installation management and employees the services provided by community resources and how they may be used to help meet the health needs of workers.

(e) Participate in community health program and professional activities and interpret to community health personnel the occupational health needs and resources of the installation. This may include provision of OH orientation or experience for nursing, medical, or other professional or technical students.

4-9. Special policies. There are certain infrequently occurring events or activities for which specific policies should be established and included in the SOP. They should also be disseminated to MEDDAC or installation personnel that may be involved.

a. Death of an employee. The installation personnel office will have a policy and procedure to follow in the event an employee dies while at work. The health clinic policy and procedure are defined in paragraphs 4-3 and 4-4, AR 40-2. Occupational health staff responsibilities may include prompt notification of the physician and other installation personnel involved, assisting with disposition of the deceased, and providing emotional support to employee's co-workers and others as indicated.

b. Disasters/major emergencies. The Plans, Operation, and Training Directorate is responsible for post-wide emergency plans. The OHS, whether it is a separate clinic or a unit of the colocated MEDDAC, must have its role in these plans clearly defined. This should include what OHS resources (facilities and staff) will be used, in what circumstances, and how. In locations subject to major emergencies due to the type of operations (e.g., chemical spills, radiation incidents, etc.) or to geographical location (e.g., floods, tornadoes, etc.), special arrangements may be needed. These may include planning for special transportation and patient care facilities and procedures, providing back up supplies, and coordinating with community health care resources that may be needed to give or receive support from the installation. At installations having a potential for an occupational health - related emergency (e.g., chemical spill, etc.), the occupational health physician or nurse shall be a member of the emergency planning group.

Section IV. Professional Policies and Procedures

4-10. General.

a. Professional policies and procedures are divided into two categories - those related to professional requirements of the staff and those concerned with the OHS staff utilization, career development, interrelationships, etc. These will be discussed in this section. More detailed information on the qualifications and functions of the various staff members will be given in chapter 5.

b. The OHS staff shall follow the professional policies and procedures of the MEDCEN/MEDDAC, as well as those of their professional organizations. In addition, individuals for whom licensure is mandatory shall meet the licensure requirements of the state in which they are licensed.

c. Civilian members of the occupational health staff are governed by the same personnel policies as other civilian employees of the Federal Agency of assignment. Such policies and related procedures usually are summarized in a handbook or similar publication made available to employees by the installation CPO. In general, they cover such personnel matters as hours of work, holidays and leave, employment and promotion, salary and wage administration, career development/training, benefit programs, security, and employee conduct. In addition, the OPM has published a series of "Federal Employee Facts" leaflets on such topics as the Federal Wage system, retirement programs, and job opportunities. Military members of the staff are governed by similar appropriate DA and local military personnel regulations.

4-11. Professional activities.

a. General. For the OHS staff to perform at their fullest professional or technical levels, all concerned (physician, nurses, auxiliary staff, management personnel) must have a clear understanding of the extent of each person's professional or technical capabilities and limitations. When questions arise in this area, they should be discussed fully by those involved (staff member and supervisor, etc.) to be sure no one is assigned duties beyond his capabilities and/or to be sure that everyone is functioning at the optimum level and is not disproportionately involved in activities more appropriately assigned to someone with less preparation or responsibility.

b. Medical directives.

(1) Professional Nurse Directives. Directives or protocols shall be written for medical treatments to be administered to ill or injured employees by the nursing staff, whether or not a physician is present. Such directives insure efficient, appropriate use of professional staff, enabling both the physician and nurses to function at the optimum level of their professional capabilities.

(a) The medical directives shall be in accordance with the anticipated requirements for patient care, capabilities of the nursing staff, and available facilities and equipment. Directives shall be written, dated, and signed by the designated physician. They shall be reviewed annually and signed by the physician. Revisions shall be made when indicated to accommodate changes in health care requirements or nursing capabilities. More definitive guidance for the development and use of medical directives for the nursing staff is found in the USAEHA guide for Development of Medical Directives for the Occupational Health Nurse.

(b) Authorization for OHNS to give out non-legend (nonprescription) drugs is contained in paragraphs 7-2, 7-S, and 7-9d(3), AR 40-2; and paragraphs 9-9a and 9-10b, AR 40-66. Additional guidance provided by HSC* states that:

- This program must be reviewed by the MEDCEN/MEDDAC Therapeutic Agents Board and approved by the Commander.

- Drugs must be non-legend, prepacked in small quantities and pre-labeled by the MTF pharmacy.

- Patient's record will be annotated by the nurse.

- A record of issues will be maintained at the clinic. The type of record should be the same as that used at the MTF pharmacy [para 4-7e(5)].

(c) In addition to directives for treatment of specific illnesses and injuries, the medical protocols should provide direction by the responsible physician for qualified OHNS to perform such nonroutine nursing functions as ordering laboratory and x-ray tests for medical surveillance examinations, reviewing and screening results of health evaluations and referral of abnormal findings to the OHMD, performance of nursing health appraisals, ordering job-related immunizations, etc. (AR 40-66).

* Letter, HSPA-P, HSC, 8 Decernber 1978, subject: Dispensing of Outpatient Non-legend Drugs by Community Health Nurses and Occupational Health Nurses (to Commanders HSC MEDCEN/MEDDAC).

(d) OHNs who are qualified as nurse practitioners and/or to perform physical assessments, diagnose, or treat patients,* shall be credentialed IAW AR 40-48 and Chapter 9, AR 40-66. In all instances, there must be a clear understanding by the physician and the OHN as to the specific qualifications of the nurse to perform any non-routine nursing functions and the protocols shall clearly state the specific scope or limitations for whatever actions the nurse may take without, or before, referral to a physician.

(e) When physician assistants (PA) are assigned to the OHS, they will be credentialed IAW 40-48 and AR 40-66.

(2) Ancillary Staff. Similar written medical directives shall be provided for ancillary nursing staff.

(a) As with directives for nurses, ancillary staff directives will be based on the anticipated need and the level of preparation of the staff. Possibly, such directives can be incorporated with those for the professional nurses with appropriate indication of any limitations for ancillary staff.

(b) AMOSISTS, specially trained medical specialists who provide treatment for military personnel, may be authorized by the MEDDAC Commander and under the direct supervision of a physician to write prescriptions for and administer selected medications IAW paragraph 7-7d(7) , AR 40-2 and chapter 7, AR 40-48.

(3) First Aid Personnel. Firemen, security guards, etc., when appropriately trained, may be designated to provide first aid care, either to supplement medical and nursing care during major emergencies or to provide first aid care after normal duty hours. They should have written procedures to follow in administering first aid which should include reporting and referral procedures as well as first aid treatment.

(4) Accessibility of Directives. The written instructions for the nursing staff and first aid personnel should be kept readily accessible in the areas where they will be used most commonly, e.g., the treatment room, first aid kit, etc.

* 1st Indorsement, HSPA-H, HSC, 10 June 1977, to letter, HSE-OO, USAEHA, 19 April 1977, subject: Medical Directives for Occupational Health Nurses.

c. Requests from employees' physicians.

(1) Personal physicians of employees occasionally request OHS staff to provide an employee with certain treatments. This may range from physiotherapy for an occupational or nonoccupational injury or arranging for a specified period of daily bed rest to a course of injections for an allergy. Compliance with such requests is authorized by Public Law 79-658 but is dependent upon availability of resources. The purpose of providing these services is to avoid lost work time such as might be required if the employee went to his physician for the treatment during duty hours or had to stay home until fully recovered from an illness or injury. The OHS staff should be aware of potential needs of employees for supplementary care (bed rest, physiotherapy) that might permit an early return to work after illness or injury and should inform the employee or his physician when this care can be given by the OHS.

(2) All local physician requests for employee treatment shall be in writing and signed by the attending physician, specify the duration of time for continuing the treatment (e.g , 3 months), and be approved by the responsible OHS physician. Determination of whether the request can be complied with is based on an evaluation of:

(a) Availability of resources. All medications shall be furnished by the employee.

(b) Potential effect on the total workload of the OHS staff.

(c) Potential benefits with regard to facilitating the employee's return to work or minimizing work time lost for health care.

(3) If the nurse or other OHS staff member has any questions about giving such treatments to employees, these shall be discussed promptly with the OHMD so the questions may be resolved. When such services can be provided, other positive benefits may include improved relationships with employees, community physicians, and supervisors. However, care must be taken to be sure that ethical and legal factors are complied with, that this is the most practical way (for the employer and the employee) to provide the required care, and that proper recording of the care given (and any employee reaction to it) is made in the individual health record and reported to the personal physician.

4-12. OHS staff professional policies and procedures.

a. Professional channels. As stated earlier, there must be a clear, well understood organization of the OHS that defines the channels of command and communication within the OHS as well as with the MEDDAC/MEDCEN, higher echelons, etc. This applies to professional as well as administrative channels.

(1) Appendix D outlines the command channels with the MEDDAC/MEDCEN and-higher echelons. When professional questions or problems cannot be answered within the OHS, itself, these command channels must be followed as indicated by the type of problem. For example, questions concerning clinical nursing actions may be referred to the Chief Nurse, DPCCM, while questions about the occupational health program would be discussed with the Chief, PVNTMED Activity. If they do not have the solutions, the questions would then be referred through the appropriate channels to higher headquarters.

(2) The professional channels within the OHS will depend on the type of unit (para 4-2).

(a) Medical direction. As stated earlier, when there is a full-time OHMD, he will provide both administrative and professional direction for the OHS. The part-time OHMD may provide some administrative guidance, and will provide the professional medical direction. The extent of his input will depend, in part, on the amount of time he is scheduled to be at the OHS. When the physician is a designated medical consultant to the OHP, with no specific time scheduled in the OHS, he usually lives only on-call or as needed medical direction and guidance for specific problems or program areas when physician expertise is required. It is important for this physician to have and take the time to become personally acquainted with the OHS staff, the overall OHP, and the major or more common OHH of the installation. This should include at least an orientation visit to the major work areas and periodic meetings with the OHS staff. Generally, the OHMD coordinates with the C, PVNTMED and/or C, DPCCM to assure appropriate OHS representation in conferences with management and on MEDDAC or installation committees where the health of the work force may be discussed. However, when he is absent or is a part-time or consultant OHMD, arrangements must be made for the senior OHN to fill this professional function. OHS staff presence at these conferences and committees, which may be in addition to DPCCM and/or PVNTMED representation, may be indicated to provide first-hand information about the OHS, its programs, capabilities, and problems, as well as to give the OHS necessary information on which to base its plans and actions.

(b) Nursing direction, guidance, and/or support. When two or more OHNs are assigned to the OHS, one shall be designated as senior OHN or OHN supervisor. This individual will provide the nursing liaison with the MEDDAC/MEDCEN nursing service. This nurse also will assure that: nursing aspects of the OHP are carried out properly, the physician is kept informed of all pertinent changes or occurrences, the nursing and auxiliary staff (civilian and military) are informed about and prepared to perform their functions, and that nursing service personnel are fully utilized IAW their professional capabilities. When the OHS is a clinic under DPCCM, clinical nursing support (HSC Regulation 10-1) is provided by the Department of Nursing through the Chief Nurse, DPCCM. When the OHS is a section of PVNTMED, consultive nursing support is provided by the Community Health Nurse and/or the Chief, Department of Nursing. In either instance, the CHN and the Chief, Department of Nursing provide guidance and support relative to their respective areas of nursing responsibility. Where there is an Ambulatory Care Nurse Clinician, this person may provide the OHN with guidance and collaboration in conducting OHN services related to preventive, rehabilitative, and other supportive health care of workers.

(c) Ancillary staff direction. The OHS ancillary staff may consist of only a secretary or clerk, or it may include a full range of civilian and military clerical and technical personnel. The OHN will provide professional direction for the nursing service ancillary staff, working through the NCOIC when one is assigned. The OHMD full time (or the OHN in his absence) will provide professional direction for the non-nursing technical staff.

b. Staffing.

(1) OHS staffing requirements are based on the type of facility (para 4-2), scope of the OHP, staff skills needed, and availability of other resources. DA Pamphlet 570-557 provides guidance for determining staff requirements. However, because of the many variables involved, this guidance must be evaluated carefully in relation to the specific needs of the installation. The Schedule X is used to validate manpower requirements. Procedures for its preparation are outlined in DA Pam 570-4. The number and distribution of staff must be related to the quantity of work and the types and levels of skills needed to conduct the program. Definition of staffing needs must be based on required program elements (para 2-12) whether or not these are being accomplished. For example, in a one nurse unit it becomes evident that additional staff will be needed to handle an increased workload of job-related medical surveillance examinations. Currently, the OHN is using a major amount of her time in clerical and technical aspects of the program to the detriment of some of the areas requiring professional skill and knowledge. This would indicate that the additional staff needs are in the area of clerical and technical skills rather than professional nursing. Thus, the addition of a clerk, rather than a second nurse, would enable both individuals to perform at levels consistent with their preparation.

(2) Processing of Schedule X's, either for routine manpower surveys or for interim requests for authorization of staffing changes, is usually the responsibility of the MEDDAC/MEDCEN Force Development Division. Preparation of each Schedule X is the responsibility of the individual MTF activity concerned. The MEDDAC/MEDCEN Force Development or personnel office will instruct and advise the various activities as to the data required and related procedures. It is important for the OHS to be as specific and factual as possible in identification of required program elements, the known and/or anticipated workload required, and the essential skills. For example, it is not enough to say the job-related medical surveillance program must be expanded to include military personnel. Specific data needed must include the anticipated number of military involved (2,000 of the 10,000 assigned are in MOS's with potential health hazard exposures), the expected scope of examinations required (of the 2,000 military, 1,500 are exposed only to hazardous noise while the other 500 have more than one type of potential exposure), and the skills involved (additional certified audiometric technician time to supplement existing staff, etc.).

(3) Relief coverage for staff members on annual, educational, or extended sick leave should be included in overall staffing and budget plans and coordinated with the MEDDAC. Where the staff is adequate, regular staff members will cover for each other and work loads should be planned accordingly. However, where the staff is smaller, other resources for relief coverage must be sought. Possible sources for this may include personnel on loan from MEDDAC, military reserve personnel needing to fulfill their active duty requirements, temporary hires, or personnel employed on a contract basis. Ideally, the same persons should be used to provide relief coverage each year or when needed in order to have minimal interruption of the OHP. In addition to the above, specifically designated and trained first aid personnel can provide limited relief coverage (first aid care) for short periods of time. It is not advisable to rely on such support for any extended time.

(4) Where there are two or three shifts operating at the installation, arrangements must be made to provide health care for those working on the evening or night shifts. If the work groups are large and there is no onsite hospital facility, this may require assignment of a nurse or medical technician to work those shifts, with on-call medical coverage. For smaller work groups, designated first aiders may be adequate. In addition, it may be desirable to arrange the duty hours of the nursing staff so a nurse is available for the first hour of the evening shift and the last hour of the night shift. Such overlapping of hours will provide for treatment or counseling of workers, as well as for accomplishing certain aspects of the physical examination program.

(5) As stated above, every effort should be made to assign staff to work that makes optimum use of their individual knowledge and skills. Where appropriate, this may include assigning specific staff members responsibility for coordinating and implementing one or more aspects of the OHP, such as the disability surveillance or hearing conservation programs. These assignments may be made on a permanent or rotating basis, depending on local circumstances .

c. Staff development .

(1) General. Professional and/or career development of OHS staff is aimed at obtaining the optimum level of performance and job satisfaction for each staff member- It begins with the initial orientation of the new staff member and continues with ongoing training and continuing education throughout the individual's career. In addition to learning new skills and techniques, staff members must have opportunities to update their knowledge in occupational health theory and practice. Identification of training requirements should be based on careful evaluation of individual or staff training needs related to individual professional growth or changing needs or operations of the OHS. When TDY training funds are limited, or are not required for local courses, staff should be granted administrative leave, as feasible.

(2) Responsibilities.

(a) It is the responsibility of the Chief, OHS, to be sure that staff members are adequately prepared to provide the essential OHS services. This involves an ongoing identification of staff training needs, defining and requesting necessary training funds, and full utilization of all available resources to meet these needs. This may include cross-training of staff to permit greater flexibility of staff assignments and insure ready availability of personnel with required skills as well as offering wider opportunities for staff career development.

(b) The individual staff member is responsible to determine personal training needs and career goals and to take optimum advantage of available training opportunities. This includes participation as an active member in professional association activities and keeping up with professional journals and related materials, attending continuing education courses, and other self-development activities.

(c) The Chief, OHS and individual staff members should coordinate to define priorities for training or related career development activities and to determine the best way to accomplish them. As certain goals or priorities are met, new ones should be developed. Where indicated by the type OHS facility, the OHS staff should coordinate with the Chief PVNTMED or Chief, DPCCM, as pertinent, to identify and obtain essential training.

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(d) When TMC or other MTF staff have ongoing responsibility for providing OH services to military or civilian workers, arrangements shall be made to orient them to the policy and purposes of the OHP and to train them in specific OH practices and procedures.

(3) Orientation.

(a) All new staff members should be given a planned orientation to the OHS, the MEDDAC, and the installation. This should include such factors as the philosophy, goals, regulations and policies, procedures, role . expectations, physical facilities, resources, and routine and special services of the activity. When necessary, this may also include instructions in specific procedures that may be new or different for the new staff member.

(b) The AAOHN Guide for On-the-Job Orientation of the Occupational Health Nurse is a useful guide for orienting not only the new nurse, but also other new OHS staff members. It offers reminders of the various factors to be covered and suggests resources that may be used to help the new staff person become familiar with the installation and the job. In addition to onsite orientation, arrangements can be made with other installations or USAEHA for orientation of individual staff members to Army occupational health programs. This is particularly useful for new personnel on a one-nurse or one-physician staff. A 1 or 2 week TDY orientation at another Army OHS, preferably within the MEDDAC, will facilitate the orientation and effective functioning of the nurse or physician.

(c) In planning to meet specific orientation needs of new staff, attention must be paid to what knowledge and skills they bring with them. Persons new to the Army system will need emphasis on Army and related Federal regulations - which ones are applicable to the OHS and how they are used - and on Army channels and resources and how to work within them. Individuals who may have worked within the Army system but are new to occupational health will need specific orientation to the OHP.

(d) The USAEHA Occupational Health Workshop and Occupational Medicine Course (for physicians, only) should be used to supplement the installations OHS orientation program. New OHS staff and PVNTMED or DPCCM key personnel new to occupational health should be scheduled for those courses as soon as possible after assignment to the OHS or to occupational health responsibilities. Dates for the courses are listed in the AMEDD Course Catalog. A certain number of spaces for military personnel are centrally funded. All civilian employees must be funded by their respective MEDDAC/MEDCEN.

(e) At installations where there is only one OHN and/or OHMD, an onsite consultation visit from USAEHA should be requested ASAP after hire to assist the new staff person in development, organization, and/or maintenance of the OHS program.

(f) With skills which may vary from clerical abilities to professional nursing, volunteer and summer-hire personnel can provide valuable assistance to the occupational health staff. As with any new employee, they will need specific orientation or training to enable them to use their skill; or to learn the new skills that may be needed for their job assignments.

(4) Ongoing training. A continuing system of OHS staff training is essential to keep staff members up-to-date in their skills and/or to prepare them to assume increasing responsibility. It is accomplished through both formal and informal activities. These range from on-the-spot instruction or guidance regarding a specific technique or procedure to attendance at courses sponsored by universities, professional associations, or similar resources. Such activities may be self initiated and/or may be arranged for by, or in coordination with, the physician in charge, the nurse supervisor, or MEDDAC personnel. To the greatest extent possible, it is important for physicians and nurses to select courses that not only meet educational needs, but also offer the approved continuing education credit units essential for licensure or certification. Following are examples of occupational health training methods that have been used at various installations or are available through other resources.

(a) OHS staff meetings are used both to review new or changed health service policies and procedures and to review or learn about clinical or technical subjects. The meetings may be held on a routine schedule or an "as needed" basis. For example, one OHS staff plans a 2-hour meeting once a month. The physicians and nurses rotate responsibility for presenting the subject matter. The physician in charge and nurse supervisor assist with selection of subjects and obtaining resource materials or personnel. Since demands for patient care prevent all staff members from attending the meeting, the presentation and resultant group discussions are taped. The tape, and any other visual aids, are then presented at a later time to those staff members unable to attend the initial meeting. At another installation with two nurses and a part-time contract physician, the physician's appointments are scheduled so there is time for the nurses to talk with him, usually over the coffee break or lunch period. They discuss clinical questions raised by the nurses, or the physician will tell them about some new medical procedures or findings that may be related to the employee health program.

(b) The inservice education programs of the MEDDAC/MEDCEN hospital or of nearby community hospitals provide a broader exposure to medical and nursing information. Schedules for these programs are usually available on request and arrangements can be made for at least one member of the OHS staff to attend and to report back to the other staff. In turn, occupational health personnel can use these programs, either in discussion periods or in specific presentations, to inform the hospital personnel about occupational health and its relationship to them.

(c) A variety of short courses are presented through CPO facilities which are pertinent to the needs of OHS staff. These include such subjects as supervision, teaching techniques, Civil Defense, first aid, safety procedures, management, and clerical or secretarial skills. On request, the installation training officer will keep the OHS staff informed about the courses and assist with scheduling health service personnel for them.

(d) Arrangements for training in special procedures, such as electrocardiography, have been made by utilizing MEDDAC/MEDCEN or community hospital resources. In addition to the initial training in the procedure, the hospital personnel have usually been available for followup guidance when the staff member puts the training into practice at the OHS. Generally, training in all essential procedures can be arranged through the MEDDAC or MEDCEN. Where the MEDDAC/MEDCEN audiologist is a certified course director, s/he can provide the specific training in audiometry and hearing conservation that is mandated by DODI 6055.3 and TB MED 501. USAEHA also offers the approved audiometry training on an annual basis and will provide onsite workshops at the installation by request. A minimum of 10 students and adequate lead time are required. As another example, some MEDDAC/MEDCENS have provided onsite training in physical assessment for nurses to enable them to be credentialed in this procedure.

(e) Reading and discussion of professional reference materials should be a continuing activity. One health service staff with limited time for reading has assigned each staff member one or two professional journals to review. Then, once or twice a month, they should plan a time to brief one another on the articles of particular interest. A suggested list of journals and texts pertinent to the occupational health service is given in section II, appendix A. Arrangements for obtaining these materials should be made through the MEDDAC, and should be included in the OHS budget.

(f) Programmed learning or self-instruction programs are available from a variety of resources. The American Nurses' Association has developed a number of these courses pertinent to the OHN. These are usually presented first in the American Journal of Nursing and then made available as separate learning packages from ANA. NIOSH, through selected universities, offers an independent study course, The Occupational Health Nurse and Employee Mental Health. Other self learning material sources (such as tapes and/or video cassettes on a wide variety of medical, nursing, and related subject areas) include the Department of the Army (Academy of Health Sciences, installation training centers, etc.), colleges and universities, and certain commercial sources such as professional book publishers.

(g) Continuing education may be specific or supplementary to occupational health. It is particularly important for career oriented staff members to be encouraged to seek out and use opportunities to broaden and enrich their professional capabilities and understanding. This includes attendance at workshops or short courses, and, where available, taking credit courses whether or not the individual is working toward a degree. Staff members who plan to earn either a baccalaureate or graduate degree should discuss these plans with both their supervisor and with the course advisor of the school that will grant the degree. It is especially important to meet with the school advisor as early as possible to assure proper selection of required and elective courses and to avoid problems or misunderstandings regarding the educational program. In certain circumstances, financial aid may be available to the individual and this should be explored through the MEDDAC POT and the University/College providing the education.

(5) OHS professional/technical reference resources. For every OHS various types of reference resources shall be readily available to provide direction or guidance for both administrative and professional aspects of the OHS operations. The staff should be encouraged to become acquainted with the reference materials and to use them as indicated.

(a) Regulations and related guides pertinent to operations of the OHP are discussed in paragraph 1-6 b and listed in section I, appendix A.

(b) Professional literature, such as texts, journals, and monographs enable the staff to keep up to date on medical and nursing practices in general, as well as in the specialty areas of occupational health and preventive medicine. As such, they enable the staff to provide quality health care and services. Section II, appendix A, lists some of the more commonly used professional references which should be available in the OHS library or reference shelf. Others may be added, depending on the needs of the installation. For example, at an installation where toxic agents are being handled, there may be a need for a more extensive toxicology reference library. When there is a need for other specific references on a one-time or limited basis because of a special problem or activity, these references may be obtained on loan from the MEDDAC, local or State universities, or USAEHA. The MEDDAC librarian can assist with such loan requests, as well as requests for bibliographic citations (some with abstracts) from Medical Literature On-Line (MEDLINE). MEDLINE is an automated literature retrieval service of the National Library of Medicine which provides rapid access to the major portion of modern biomedical literature. Requests for MEDLINE data may be made to any major medical library, such as at MEDCEN, School of Medicine, Public Health, or teaching hospital libraries.

d. Performance evaluation .

(1) Evaluation of staff performance is a continuing process, wherein the annual performance review is a summary of progress and growth during the previous year and is the time to set short- and long-term goals for the career progression of the staff member. The annual evaluation should be geared to the job description, standards of performance (chap 5), and specific individual goals set at the previous evaluation. The evaluation should be a combined effort of the staff member and the supervisor. Separately, they should evaluate the individual's performance and identify particular needs and goals for improvement and career development. These assessments, then, should be compared during the evaluation conference, and differences and similarities discussed and/or resolved. The supervisor and staff member should explore means for building on strengths or eliminating weaknesses in the staff member's performance. The supervisor should be alert to staff members with particular strengths, such as leadership potential, and encourage and assist them, as possible, to prepare for more advanced positions. When the annual review identifies areas in the job description that are no longer consistent with what the staff member is doing or supposed to be doing, recommended changes to the job description shall be prepared and forwarded through channels to the CPO for action. This applies whether or not the proposed revision requires a change in job status (grade level, etc.).

(2) The annual performance review does not obviate the need for ongoing performance evaluation. This is essential. Each staff member needs to know at the time of occurrence when performance in a particular area is significantly weak so that immediate action can be taken to correct the situation. Similarly, particular examples of better than usual performance should be acknowledged promptly to enhance the individual's job satisfaction. All such events (positive and negative) should be properly documented and filed by the supervisor with copies in the individual's OPF when indicated. Without this documentation, the supervisor has limited data on which to base any adverse actions for the consistently poor performer, or positive actions for the outstanding performer.

(3) During the probationary period for new employees, ongoing evaluation and documentation of the individual's performance is particularly important. Such careful observation is essential to obtain and maintain the best possible staff.

e. Public relations. In addition to the occupational health education and orientation of installation personnel, there are occasional opportunities to interpret occupational health and/or the Army's OHP to non-installation personnel, either individuals or groups, and to seek and encourage cooperation in areas of mutual concern.

(1) The most common activity in this area is the contact with local physicians, nurses, or other community health agency personnel regarding the health needs of a specific worker. (This includes coordination with MEDDAC/MEDCEN staff in relation to military employees.) The time taken to explain the OHP, policies, and resources almost invariably pays off in the resultant quality of cooperation in helping the employee cope with his health problem. In turn, the health service staff can gain more complete information regarding the extent of services available from the community resource.

(2) OHS staff at installations located near schools of nursing or medicine have provided occupational health orientation for their students. In some instances this has been limited to the occupational health physician or nurse presenting a lecture on the subject at the school. In others, arrangements have been made for the students to visit the health service. Such field visits have ranged from a 4 to 6-hour observation visit for an entire class to more comprehensive 3 to 5 day orientation for 1 to 3 students at a time. The latter programs have included some supervised participation by the student in the OHP. This may have been application of a simple dressing, the taking of a health history, or initial nursing screening tests for routine physicals. Care must be taken when establishing student orientation programs to coordinate with MEDDAC and installation personnel (e.g., legal, administrative, and other professional staff) regarding security, liability, affiliating agreements, and other administrative factors. There should also be a clear understanding and agreement with the school faculty regarding the objectives and scope of the student program and the responsibilities of all concerned, including the students. The faculty should be encouraged to visit the installation prior to the student visits to determine what learning experiences are available and work out the best method for providing them.*

(3) Installations cooperating with local high school career planning programs have also included the occupational health service in the students' observations. These are usually walk-through visits which should be planned to make the best use of the available time and appeal to the imagination of the student without interfering with OHS operations.

(4) As noted earlier, when OHS staffs have developed programs or procedures that have been particularly effective and might be adaptable to other installations and/or of interest to other DA, Federal, or private industry programs, the staff involved are encouraged to write up these activities for publication or presentation at professional conferences.

* The Student Nurse in Industry , American Association of Occupational Health Nurses, Inc., New York, NY.

CHAPTER 5

OCCUPATIONAL HEALTH PERSONNEL

Section I. Introduction

5-1. General. This chapter discusses the functions, responsibilities, and qualifications of the various staff members most frequently found on the Occupational health team. This includes personnel whose primary duty assignment may be to units other than the OHS (e.g., audiology, optometry, etc.) but who have specific designated responsibilities for occupational health. Chapter 5 also gives an overview of various factors and actions involved in establishing and maintaining positions.

5-2. Establishment of positions.

a. Coordination with CPO. All actions concerning civilian job positions will be coordinated with the CPO. In conformity with OPM direction, the CPO provides local guidance and establishes local procedures for all civilian personnel actions. The CPO is also-responsible for rating jobs, recruiting candidates, and assisting with job actions such as promotions, fitness-for-duty evaluations, terminations, etc.

b. Job descriptions. When the need for a position has been identified, the Schedule X prepared and submitted, and the position recognized and authorized (para 4-12b), a job description must be prepared. While the CPO provides the technical guidance for setting up a job description, it is the responsibility of the MTF to provide the professional and administrative information on the functional content and controls of the job. This includes definition of supervisory controls, areas of dependent and independent actions, and major duties and responsibilities of the position. Preparation of the job descriptions must take into account the definition of major and critical elements of the position which provide the basis for determining the various tasks or duties to be performed. Specific guidance for developing major/critical elements and delineation of tasks is available from CPO. The OPM uses the Factor Evaluation System (FES) for all nonsupervisory positions. In addition to listing duties and responsibilities for each position, the job description identifies and describes nine factors of the job: knowledge required by the position, supervisory controls, guidelines, complexity, scope and effect, personal contacts, purpose of contacts, physical demands, and work environment. The grade level for the position is based on numerical scores given for each factor by the CPO in coordination with the supervisor. Guidance on writing job descriptions under this system is contained in the OPM Instructions for the Factor Evaluation System (sec I, app A). This system is being initiated on a progressive basis by job classes, with specific guidance being developed for each class. The FES has completed the nurse series, the secretary series, and the industrial hygiene series. Completion of the physician series is scheduled for FES development. Even though OPM FES guidelines have not been developed for every class of OHS staff position, consideration should be given to using the general FES guidelines along with the existing job series guidelines in preparing job descriptions for new positions being established or for upgrading existing positions. Such guidance is useful in preparing descriptions that clearly describe and emphasize key duties and levels of responsibility. Further guidance on use of the FES is given in appendix Q using the OHN position as the example.

c. Skills, knowledge, ability, personal characteristics (SKAP's). When the job description has been completed, it must be analyzed to determine what worker characteristics or SKAPS are essential for successful job performance. SKAP for each major duty are defined and described by the supervisor. Then, for each SKAP, level descriptions are assigned, giving examples of qualifying characteristics progressing from the barely acceptable level to superior. These are used to assess the candidate's qualifications for the position. For example, using the OHN position, the minimum acceptable level of nursing knowledge for a staff OHN might be a diploma graduate with knowledge gained from at least 1 year's experience in an emergency room or outpatient clinic service. The superior level would be a baccalaureate graduate with courses in occupational health, toxicology, etc., experience in occupational health or public health nursing, and certification in occupational health nursing.

d. Basic qualifications. Minimum DA and/or OPM requirements for hiring or assigning civilian or military personnel have been defined. These cover such basic qualifications as education and specialty training, internships or residencies, licensure, and physical requirements. The OPM Handbook X118 describes the qualifications for each civilian job series (GS 602-medical officer, GS 610-nurse series, GS 621 and 699-nursing assistants and health technicians, GS 690-industrial hygienist, GS 300-clerk, etc.). AR 611-101 describes the commissioned officers qualifications IAW the specialty skill identifier (SSI)(SSI 60C-preventive medicine officer, SSI 60D-occupational medicine officer, SSI 66B-community health nurse, SSI 68M-audiologist, SSI 68K-optometrist, SSI 68N-environmental science officer, SSI 68P-environmental engineer, etc.). AR 611-201 describes enlisted personnel qualifications IAW military occupational specialty (MOS) codes (MOS 913-medical specialist, MOS 91C-clinical specialist, MOS 91S-environmental health specialist, MOS 910-'NT specialist, MOS 91Y-eye specialist, etc.). More specific qualifications for key OHS positions will be discussed in subsequent sections of this chapter, as appropriate.

5-3. Standards of Performance. When an individual is assigned to a position, he must be informed not only about the functions of the job, but also the standards of performance that are expected and will be used as a basis for performance evaluation (para 4-12d). For each major duty, the supervisor will define the acceptable level of performance and review this with the employee. The job description and the SKAP for the position provides a basis for development of the performance standards. Examples of performance standard statements for certain functions of selected OHS staff members are given in appendix R.

5-4. Professional responsibilities. In order to maintain competence to perform their jobs, all professional and technical members of the OHS have a personal responsibility to:

a. Maintain current licensure and/or certification IAW legal and/or Professional requirements.

b. Maintain active membership and participation in the appropriate professional or technical association.

c. Take action for self-improvement through participation in continuing education programs (short courses or formal education).

d. Make appropriate use of available consultant resources.

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Section II. Occupational Health Physician

5-5. General. The OHMD may be military or civilian and may be assigned as an on-call consultant or as a part-time or full-time member of the OHS staff. The occupational health medical consultant or part-time physician may be assigned full-time to the MEDDAC/MEDCEN with other--usually primary--nonoccupational health functions (e.g., physical examinations, other DPCCM duties, preventive medicine, etc.), or s/he may be a contracting physician assigned only to the occupational health program. The full-time physician usually is a civilian employee.

5-6. Qualifications.

a. All physicians are required to be currently licensed medical doctors or doctors of osteopathy.

b. Preferably, the full-time physician and the contracting consultant will be either board eligible or board qualified in occupational medicine or preventive medicine. As a minimum, the physician should have education and/or experience in the areas of occupational health, occupational diseases, toxicology, epidemiology, preventive medicine, industrial hygiene, legal and regulatory requirements, etc. The American Board of Preventive Medicine has outlined the areas of knowledge of concern to the occupational health physician (app S).

c. The physician assigned part-time preferably will have at least a background orientation to preventive medicine and/or occupational health, and will, as indicated, be provided courses or specific orientation in such areas as occupational health and occupational diseases and hazards, as well as DA occupational health standards, policies, and requirements.

d. After hire, it is particularly important that the OHMD become well informed about the various types of work and operations performed at the installation. This is essential to intelligent medical decisions on worker's physical suitability for jobs; determination of job-related medical surveillance requirements; and prevention, control, and/or early detection of adverse effects of the Job assignment on the worker.

e. The American Occupational Medical Association has adopted a code of ethics which provides guidance to physicians in meeting their responsibilities (app T).

5-7. Functions.

a. As stated earlier, it is essential that a physician be designated the responsibility for directing medical aspects of the OHP. Whether this is on a full-time, part-time, or consultant/on-call basis, the physician's assignment orders, job description, or contract should specify the scope of the physician's authority for medical and administrative (when applicable) direction of the OHP. The extent of the physician's functions will depend on the needs of the program and the amount of time the physician is assigned to occupational health.

b. The most common functions of the full-time physician are listed below. These may be performed independently or in collaboration with the OHN or with other MEDDAC/MEDCEN and installation staff.

(1) Provides overall medical direction for the OHP.

(2) Determines the scope, policies, objectives, and specific goals of the OHP IAW with regulatory and legal requirements and the particular needs and resources of the installation (sec IV, chap 2); participates in the development of the local OH regulation or supplement to AR 40-5.

(3) Plans, conducts, and evaluates the OHP; develops and manages the occupational health budget.

(4) Consults with and advises installation management (commanders and division and line supervisors) regarding occupational health matters.

(5) Evaluates the work environment from a health standpoint and coordinates with appropriate personnel in recommending preventive or corrective actions; visits work sites periodically and as needed.

(6) Reviews the inventory of hazards and the list of positions with physical fitness requirements to determine requirements for and conducts or coordinates provision of job-related preplacement, periodic, and termination medical evaluations. Assists with proper employee assignment by determination of the employees' physical and emotional capabilities. Provides fitness-for-duty and disability retirement examinations as requested.

(7) Assures provision of prompt, appropriate diagnosis, treatment and/or referral, and followup of illnesses and injuries; provides written medical directives for nursing staff treatment of illnesses and injuries and medical protocols for extended independent nursing functions; and instructions for ancillary first-aid personnel; assures complete recording and reporting of all occupational illnesses and injuries; conducts epidemiological studies of all occupational illnesses and unusual incidents of injuries and recommends remedial action.

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(8) Provides medical aspects of job-related health education of workers.

(9) Provides medical support of the illness absence control program; coordinates with the personnel office in development of policy for evaluating employees' fitness for return to work after illness; makes recommendations about changes in work (temporary or long term) indicated by employee's physical (or emotional) status.

(10) Confers with personal physicians on employee health matters related to job performance, such as pregnancy, work health hazards, job physical requirements, etc.

(11) Determines requirements for job-related immunizations.

(12) Coordinates with the OHN to develop a program for health education and counseling in the areas of health maintenance, prevention and early detection of illness, etc.

(13) Assures proper preparation and maintenance of occupational health records and reports; uses reports as tools for program evaluation and planning.

(14) In accordance with available resources and employee needs and in coordination with the OHN and other MTF or community health resources, arranges for elective health screening programs (single disease screening, nursing health appraisals, multiphasic screening programs).

(15) Coordinates with other MTF or installation personnel having functional input to the OHP (audiologists, optometrists, radiologists, laboratory staff, PAD, civilian and military personnel officers, division and flight surgeons, safety officers, etc.).

(16) Participates on the safety and health committee and serves as occupational health consultant to other committees or activities related to health of workers (radiation protection committee, hospital infection control, etc.).

(17) Provides or coordinates orientation to the OHP for employees, supervisors, MTF staff with related responsibilities, community physicians, and other health resource people.

(18) Provides direction and guidance to occupational health staff; plans, conducts, or coordinates periodic staff meetings, inservice training, and continuing education for OHS staff; provides performance evaluation, technical and administrative advice, and assistance with work and career development planning.

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c. The functions of part-time or consultant physician generally are more limited, with the OHN carrying more of the administrative and coordination functions. Usually, the part-time OHMD will provide:

- (1) Medical direction of the OHP
- (2) Medical consultation to the OHN on:
 - (a) Development of program goals and objectives and program evaluation
 - (b) Health aspects of work hazard evaluation
 - (c) Determination of job-related medical surveillance requirements
 - (d) Epidemiologic investigation of occupational illnesses
 - (e) Job-related health education
 - (f) Coordination with local physicians
 - (g) Coordination with other MTF and installation staff
 - (h) OHS staff training and development
- (3) Job-related medical surveillance examinations or review of and recommend actions on abnormal findings of such examinations conducted by other MTF resources.
- (4) Medical directives or protocols for the OHN and ancillary staff.

d. When the occupational health service is a part of an Army health clinic, two or more physicians may be assigned to the clinic. In such instances, one should be designated as the occupational health physician. This individual may serve in that capacity either full-time or part-time depending on the needs of the installation.

Section III. Occupational Health Nurse

5-8. General. The occupational health nurse is a professional registered nurse who works under the medical direction of and in collaboration with the occupational health physician. In addition to the traditional concepts of therapeutic nursing practice, the OHN utilizes the principles of prevention, health promotion, health education, and ergonomics to assist the worker maintain his health. The OHN is a full-time civilian employee. Other civilian and military nurses may be involved in various aspects of the OHP (e.g., supporting clinic nurses, community health nurses serving as chief of PVNTMED, etc.) but they are not designated as OHN's.

5-9. Qualifications.

a. Selective placement criteria for OHN's include graduation from an accredited baccalaureate school of nursing, current state licensure, and a minimum of 1 to 2 years of professional nursing experience.

b. The following additional preparation, experience, and demonstrated skills and abilities must be considered when a candidate is applying for a position or promotion in OH nursing.

(1) Preparation in occupational health through formal academic programs or continuing education short courses. This should include such subjects as management principles; employee relations; industrial toxicology; occupational disease cause, prevention, control, and treatment; industrial hygiene principles; job-related medical surveillance principles and practices; health education; epidemiology; legal and regulatory aspects of occupational health; and other areas specific to the practice of occupational health nursing.

(2) Experience in occupational health, public health, general outpatient or emergency clinic service, or other nursing service requiring initiative and independent professional judgment.

(3) Certification as an OHN.

(4) Demonstrated skill and judgment in dealing with people and in helping them to assume appropriate responsibility for their own health maintenance.

c. The OHN serving as program administrator/coordinator or supervisor should have preparation and/or experience in administration, supervision, and personnel management.

d. Some nurses have become prepared in and qualified to perform physical assessment procedures over and above the basic nursing assessment procedures. Such nurses, under appropriate medical protocols, are able to perform a wider range of health evaluation and patient care functions in the OHP.

e. All OHN's, as with the OHMD, have the requirement to be well acquainted with the installation, its organization and mission, work areas and processes, key personnel, potential health hazards and their control, etc.

f. More specific occupational health nursing preparation or experience requirements will depend on the mission and work processes of the installation. Usually, such specialized knowledge is provided as part of the orientation or inservice education program. For example, at an installation where highly toxic chemicals are used, the OHN will need to know what these chemicals are; where and how they are used; prevention, control, effects, and treatment of overexposure; and medical surveillance requirements.

g. The Code of Ethics for Occupational Health Nurses developed by AAOHN is shown in appendix U.

S-10. Functions.

a. The extent of functions of any OHN will depend on such factors as the extent of medical direction, the policy and scope of the specific OHP, the type, size, and capabilities of the OHS staff, the preparation of the OHN, etc. The following list of functions describes areas where the professional nurse can contribute most effectively to the accomplishment of the OHS mission. The functions are listed by major OHS program or functional areas rather than by job category or priority. Priorities for implementation of nursing services should be based on overall OHS priorities, as determined by the medical and nursing staff.

b. Coordinates with the OHMD to plan, implement, and evaluate the OHP.

(1) Collaborates in formulation of OHS policies, objectives, and standards; participates in the development of the local OH regulation or supplement to AR 40-5.

(2) Plans, organizes, and implements an efficient occupational health nursing service consistent with the objectives and scope of the OHP.

(3) Identifies health needs of employees and participates in developing programs, or identifying other resources, to meet these needs.

(4) Collaborates in the development and-maintenance of the OHS SOP; provides nursing aspects of the manual.

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(5) Participates in formulation and maintenance of medical directives and nursing protocols within the scope of the Nurse Practice Act and DA regulations.

(6) Collaborates in development of the OHS budget; recommends needs related to the nursing service and staff.

(7) Collaborates in planning, use, and maintenance of physical facilities, equipment, and supplies.

(8) Collaborates in evaluation of the occupational health service programs and procedures in relation to objectives and standards; recommends actions to increase effectiveness.

(9) Participates in research and studies for improvement of the delivery of health care; initiates studies specific to nursing.

(10) Collaborates in conducting periodic audit of medical and nursing programs, procedures, and records and recommends changes as indicated.

c. Coordinates with the physician and others concerned with the OHS aspects of development and maintenance of the installation inventory of potential occupational health hazards and the list of positions with physical fitness requirements.

(1) Periodically visits work areas to gain familiarity with installation operations and special problem areas.

(2) Develops and maintains a system to be sure the OHS is kept informed about all occupational health hazards and any changes or new processes and substances; collaborates with the OHMD and others concerned in advising management about potential health problems related to work operations and in recommending preventive or corrective action.

(3) Coordinates with the physician, safety, and personnel offices to identify all positions with physical fitness requirements and to insure proper and full utilization of workers with physical or mental disabilities.

d. Coordinates with the OHMD in implementation of the health evaluation and job-related medical surveillance program [see also 3-3b(2)2.

(1) Coordinates development of a system to be sure all personnel requiring job-related medical surveillance are identified, specific medical surveillance requirements are defined by the OHMD, and examinations (preplacement, periodic, special, and termination) are scheduled as required.

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(2) Obtains health and work histories; arranges for, performs, or supervises performance of screening tests, laboratory tests, and other test measures indicated by the history, health hazard exposures, or fitness requirements of the work assignment. When qualified and credentialed, conducts physical assessment aspects of the examination.

(3) Reviews the results of histories, screening tests and observations; makes referrals to the OHMD; and interprets results to the worker IAW protocols established with the OHMD.

(4) Insures that the worker understands the purpose and results of the examination; makes referrals to appropriate medical resources.

(5) Conducts an after-hire baseline health screening of new employees who were not required to have a preplacement physical examination.

(6) Coordinates with the physician in determining needs and resources for voluntary health evaluation programs, conducts or arranges provision of such programs, when indicated.

(7) Assures proper patient followup of routine and special health evaluations.

(8) Evaluates and reports on all routine and special health evaluation programs, identifying both negative and positive effects and recommending action to improve effectiveness.

e. Provides nursing care of illness and injury, including referral and followup, IAW written medical directives and protocols.

(1) Coordinates with the physician in development and periodic review of medical directives for treatment of illness and injury by nurses and for first-aid treatment by ancillary nursing staff and first-aiders.

(2) Instructs (or arranges for instruction) and supervises ancillary OHS personnel in first-aid procedures.

(3) Identifies health care needs of employees; correlates presenting symptoms with potential job exposures; develops and implements nursing care plans to include initial and continued care, rehabilitation, and return to work; initiates epidemiologic investigations where indicated; and consults with the employee's physician regarding employee's work exposures and OHS resources to facilitate care and assist with rehabilitation of the employee.

(4) Coordinates with OHMD and with installation personnel, as indicated, to develop and maintain a system for handling major emergencies and/or disasters.

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f. Coordinates with the OHMD, safety and personnel officers, and others concerned to provide a health education program to include:

- (1) Prevention and control of job-related health hazards.
- (2) Orientation to the OHS and how to use it and the purpose and scope of routine and special programs.
- (3) Supervisor training relative to health and safety of employees and areas for coordinated action.
- (4) General health maintenance education through individual counseling, articles in post publications, pamphlets, posters, group programs on specific health problems, and advice concerning available local health resources.
- (5) Coordinate with the ADAPCP officer in support of the alcohol and drug abuse program.

g. Arrange for employee immunizations IAW needs of the work assignment.

h. Develops and conducts preventive programs related to:

- (1) Sickness absence control.
- (2) Personnel with chronic diseases or disability.
- (3) The pregnant employee.

i. Coordinates with the OHMD and PAD to develop and maintain a record and reporting system consistent with legal and regulatory requirements and that insures continuity of care; maintains medical confidentiality of care; and facilitates patient care and OHS evaluation, planning, and reporting. Provides orientation and training of personnel having input to the OHS records and reporting system and supervises OHS staff in regard to records and reports activities.

j. Coordinates with the OHMD to provide for OHS staff development through ongoing inservice education (both OHS and MEDDAC), provision of professional reference materials, and scheduling for continuing education programs. Supervises nursing and ancillary staff, counseling them regarding opportunities for self-development.

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Section IV. Industrial Hygienist

5-11. General. The industrial hygienist or technician may be civilian or military. He may be assigned full-time to industrial hygiene functions at one installation or at more than one installation supported by the MEDDAC/MEDCEN. He may have other duties (environmental health) in addition to industrial hygiene, or the environmental science officer (ESO) will be assigned the industrial hygiene function in addition to his other duties. Not all installations will have an industrial hygiene staff but will rely on the MEDDAC/MEDCEN industrial hygiene/environmental health staff or USAEHA Regional Offices for industrial hygiene consultation and support.

5-12. Qualifications.

a. Industrial hygienist.

(1) A minimum of a baccalaureate degree (including at least 15 semester hours of chemistry) and 1 year of graduate course work in industrial hygiene or related field (engineering, physical or natural science, public health, etc.). Other preferred course areas include physics, environmental health, biostatistics, toxicology, epidemiology, etc.

(2) A minimum of 2 years experience in industrial hygiene or related area.

(3) Additional education and experience requirements are dictated by the grade level and type position.

(4) Preferably, the industrial hygienists will be certified industrial hygienists and/or professional engineers.

b. Industrial hygiene technician.

(1) A minimum of a baccalaureate degree or an equivalent combination of education and experience in industrial hygiene or related fields, including at least 12 semester course hours in chemistry. Preferred education subjects areas are similar to those of the industrial hygienist.

(2) A minimum of 1 year experience (beyond the academic/experience requirement) in industrial hygiene or related fields, as for the industrial hygienist.

(3) Additional education and experience requirements are dictated by the grade level and job assignment.

(4) Preferably the industrial hygiene technician will be a certified technician.

5-13. Functions.

a. The functions of the industrial hygienist and the technician generally cover similar activities. Because of his/her advanced preparation and experience, the industrial hygienist will provide program leadership, exercising greater responsibility, handling the more complex problems, and providing consultation and guidance to the technician.

b. The more common functions of the industrial hygiene staff include:

(1) Develop and maintain an inventory of all potential occupational health hazards and collect data on the toxicity of chemicals in use; provide the OHS with a copy of the current hazard inventory.

(2) Frequently inspect worksites to identify changes in operations and determine if control measures are in use and functioning properly.

(3) Survey operations periodically by taking air samples, noise measurements, etc., to determine exposure levels associated with tasks.

(4) Evaluate operations, using survey data, to determine if permissible exposure limits are exceeded and whether work practice changes, engineering controls, or personal protective equipment can be used to reduce exposure levels. Assign risk assessment codes to prioritize OSHA compliance efforts. Maintain a record of findings, evaluations, and recommendations for controls.

(5) Provide industrial hygiene advice and consultation in planning and design of new worksite facilities or operations to avoid introduction of occupational health problems.

(6) Advise management on the design and proper use of industrial hygiene controls such as engineering controls, respirators, ventilation, protective clothing, posted areas, etc., IAW legal, regulatory, and professional standards.

(7) Investigate special problems and employee complaints and coordinate with safety, management, the OHMD, and others concerned to alleviate the problem.

(8) Collaborate with safety, OHS staff, and others to provide job-related health education for employees.

(9) Collaborate with the OHMD in identifying occupational health hazards requiring medical surveillance.

(10) Determine the type of equipment needed to evaluate hazards and control measures and be familiar with its proper use. Maintain and calibrate equipment IAW Army regulations and the manufacturer's specifications.

Section V. Ancillary Staff

5-14. General. The types and numbers of ancillary staff will vary IAW the type and size of OHS. It may include military or civilian personnel in such categories as practical nurses, nursing assistants, medica, technicians, occupational health technicians, and laboratory and/or x-ray technicians. In addition, MEDDAC optometry and/or audiometric technicians and PVNTMED environmental health technicians may provide significant support to the program.

5-15. Qualifications. Military ancillary staff should have the basic and advanced training established by DA for their specialty areas. Civilian employees should have equivalent training and/or experience. Where there are specific legal requirements, such as for x-ray technicians, these must be complied with. Frequently, it is necessary for ancillary staff to substitute for each other or serve in more than one specialty area. In such instances the staff must be appropriately cross-trained. Further, the ancillary staff should be oriented to the installation as this relates to the OHP.

5-16. Functions.

a. General. Ancillary staff functions in the OHS are similar to those of the technical staff in other MEDDAC clinic facilities. To the greatest extent possible, they should be given responsibility, under appropriate supervision, for particular OHS program areas. For example, a medical or occupational health technician with proper training and supervision can manage the occupational vision program as a part of his/her overall OHS functions. In a number of instances laboratory or x-ray technicians also have such additional duties as performing electrocardiograms or pulmonary function testing.

b. Occupational health technician (OHT). The functions of the recently introduced position of the OHT provide an overall view of ancillary technical staff functions, depending on the individual's preparation and other (primary) duties.

(1) Participates in the OH medical surveillance program by preparing patient and equipment for examination, performing selected screening tests (audiograms, electrocardiograms, vision screening, etc.), making referrals to the OHN or OHMD, and assisting with followup.

(2) Manages selected supplements of the OHP, such as the vision program.

(3) Provides treatment of illness and injury IAW medical directives and level of preparation.

(4) Participates with OHN and OHMD in worksite visits.

(5) Assists with employee health education program.

(6) Assists with maintenance of the OHS record and report system.

Section VI. Clerical Support Staff

5-17. General. Usually, clerical support staff are civilian employees. However, military personnel may be assigned as records clerks or to other clerical or administrative duties.

5-18. Qualifications.

a. Clerical/secretarial staff should have training and experience in typing, filing, and other office procedures commensurate with OPM standards. They should also demonstrate tact and patience in dealing with employees, recognize the importance of maintaining confidentiality of medical information, and be able to react appropriately in emergencies.

b. Personnel responsible for medical records should also be trained or experienced in medical records procedures, including DA practices for initiation, maintenance, filing, and disposition of medical records and suspense files.

c. At certain installations, clerks may also be required to be trained in such procedures as first aid or audiometric and vision screening. Usually this training is provided either on the job or through approved courses after the individual is assigned. This requirement must be reflected in the job description.

5-19. Functions.

a. When there is only one clerical support person, that individual will be responsible for all clerical, records, and receptionist duties. On larger staffs, one person should be assigned the responsibility for overall coordination of clerical support activities and each member should have designated areas of responsibility. All staff members should be cross-trained to assure continuing smooth functioning of administrative aspects of the OHS.

b. Functions of the OHS clerical staff include:

- (1) Maintenance of OHS administrative records and files.
- (2) Preparation of all correspondence, reports, and forms IAW pertinent instructions and accepted format.
- (3) Maintain the OHS daily log.
- (4) Serve as OHS receptionist, receive patients, pull health records, direct patient to OHN or other OHS staff for care, answer the telephone, assist with patient's transportation arrangements as necessary, etc.

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(5) Maintain OHS medical records; initiate records for new employees; prepare laboratory, x-ray, and other medical request forms; maintain suspense files on all incomplete records; file medical tests and related reports after nursing and/or medical review; refer all OWCP records to CPO; assure safety is provided pertinent information regarding occupational injury or illness; prepare and refer medical records of transferred or terminated employees; etc.

(6) Schedule all routine examinations as directed.

(7) Order and maintain office supplies and forms.

(8) Maintain a current listing of persons and agencies (installation, MEDDAC, community) that may be useful resources in relation to occupational safety and health matters.

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Section VII. Other Personnel

S-20. Audiologist.

a. The audiologist usually is military but may be a civilian employee. He must have a masters degree and be eligible for or certified by the American Speech and Hearing Association. Although not a member of OHS staff, per se, he usually spends half-time in the occupational hearing conservation program.

b. The audiologist is responsible for the following functions.

(1) Direct the hearing conservation program, to include preparation and maintenance of the program SOP, coordinating this with the OHMD/OHN as indicated.

(2) Coordinate with industrial hygiene and/or safety to identify and maintain an inventory of noise-hazardous work areas or jobs.

(3) Provide or assure provision of audiometric testing of personnel in noise-hazardous jobs or areas.

(4) Identify requirements for and assure provision and fitting of hearing protection by medically trained personnel.

(5) Coordinate with safety, management, and others concerned to prevent establishment of, eliminate, or control noise-hazardous work areas.

(6) Coordinate with OHS and safety staff to provide employee health education regarding hearing conservation.

(7) Prepare and maintain noise exposure and audiometric records IAW TB MED 501.

5-21. Optometrist.

a. With a few exceptions the optometrist is a military officer assigned to the Optometry Clinic and providing consultant services to the OHS. He is required to complete a 4-year education program in optometry, following 3-4 years undergraduate work, and be licensed.

b. Functions of the optometrist related to the occupational vision conservation program (TB MED 506) include:

(1) Provide guidance to the OHS in development and maintenance of the occupational vision program.

(2) Coordinate with safety to identify requirements for and assure provision of, employee eye protection equipment.

(3) Provide or assist with vision screening of personnel in eye-hazardous areas, to include provision of, or arranging for provision of, refractions for personnel needing prescription industrial safety glasses.

(4) Provide, or assist with, the fitting, verification, and adjustment of plano/prescription industrial safety glasses.

(5) Coordinate with safety and OHS staff and others to provide worker health education concerning vision conservation.

5-22. Division and flight surgeons. Division and flight surgeons have preventive medicine and occupational health responsibilities for the military personnel they support. Because of this, and as has been noted earlier, the OHS staff should establish a communication system with them. This is necessary to be sure they are kept informed about new or specific occupational health requirements, guides, or resources and that there is appropriate coordination of related services, including recording and reporting of occupational health data.

5-23. Safety officer.

a. The safety officer assigned to the MEDDAC/MEDCEN hospital, as with the installation safety officer, is usually a civilian, but may be military. Preferably s/he has at least a baccalaureate degree with preparation and experience in safety.

b. Functions of the safety officer are similar to those of the industrial hygienist but focus on safety, rather than industrial hygiene hazards. These may include [see also para 4-8c(5)]:

(1) Identify, prevent, and control safety hazards.

(2) Maintain an inventory of safety, including eye, hazards.

(3) Provide safety consultation regarding the design, development and engineering of facilities, equipment, systems, processes, methods, and operating procedures.

(4) Advise management on requirements (OSHA and other) for safety controls.

(5) Investigate accidents and other safety problems and recommend corrective actions.

(6) Provide safety education of workers.

(7) Coordinate the safety and health committee activities.

(8) Identify positions requiring physical fitness.

(9) Maintain safety records and reports.

APPENDIX A

REFERENCES

Section I. Regulatory

A-1. ARMY REGULATIONS.

AR 1-35, Administration, Basic Policies and Principles for Interservice, Interdepartmental, and Interagency Support.

AR 5-1, Army Management Doctrine.

AR 10-5, Organization and Functions, Department of Army.

AR 10-43, Organization and Functions, United States Army Health Services Command.

AR 18-1, Management Information Systems: Policies, Objectives, Procedures, and Responsibilities.

AR 40-1, Composition, Mission, and Functions of the Army Medical Department.

AR 40-2, Army Medical Treatment Facilities, General Administration.

AR 40-3, Medical, Dental, and Veterinary Care.

AR 40-4, Army Medical Department Facilities/Activities.

AR 40-5, Preventive Medicine.

AR 40-14, Control and Recording Procedures for Occupational Exposure to Ionizing Radiation.

AR 40-15, Medical Warning Tag and Emergency Medical Identification Symbol.

AR 40-26, Tuberculosis Detection and Control Program.

AR 40-46, Control of Health Hazards for Lasers and Other High Intensity Optical Sources.

AR 40-61, Medical Logistics Procedures and Policies.

AR 40-48, Health Care Extenders.

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AR 40-62, Standard Policies, Definitions, and Data Presentations Relating to Fixed Medical Treatment Facilities and Patient Accountability.

AR 40-66, Medical Record and Quality Assurance Administration.

AR 40-330, Rates for Army Medical Service Activities.

AF 40-332, Preparation of DD Forms 7 and 7A for Billing Purposes.

AR 40-400, Patient Administration.

AR 40-418, Medical Statistical Reporting.

AR 40-501, Standards of Medical Fitness.

AR 40-562, Immunization Requirements and Procedures.

AR 40-583, Control of Potential Hazards to Health from Microwave and Radio Frequency Radiation.

AR 50-5, Nuclear Surety.

AR 50-6, Chemical Surety Program.

AR 95-I, Army Aviation: General Provisions and Flight Regulations.

AR 140-120, Medical Examinations.

AR 230-2, NAF and Related Activities, Personnel Policies and Procedures.

AR 230-16, NAF and Related Activities, Risk Management Program.

AR 310-I, Publications, Blank Forms, and Printing Management.

AR 310-2, Identification and Distribution of DA Publications and Issue of Agency and Command Administrative Publications.

AR 340-18-9, Maintenance and Disposition of Medical Functional Files.

AR 351-3, Professional Training of Army Medical Department Personnel.

AR 360-5, Public Information Policy.

AR 385-10, Army Safety Program.

AR 385-11, Ionizing Radiation Protection.

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AR 385-30, Safety Color Code Markings and Signs.

AR 385-32, Protective Clothing and Equipment.

AR 385-40, Accident Reporting and Records.

AR 385-80, Nuclear Reactor Health and Safety Program.

AR 415-10, General Provisions for Military Construction.

AR 600-8, Military Personnel Offices.

AR 600-85, Alcohol and Drug Abuse Prevention and Control Program.

AR 611-101, Commissioned Officer Specialty Classification System.

AR 611-201, Enlisted Career Management Fields and Military Occupational Specialties.

A-2. FIELD MANUALS.

FM 8-21, Field Medical Support Guide.

FM 8-24, Community Health Nursing in the Army.

FM 8-36, The Aidman's Medical Guide.

FM 101-5, Staff Officers Field Manual, Staff Organization and Procedure.

A-3. TRAINING CATALOGS.

TC 8-1, Training in First Aid and Emergency Medical Treatment.

TC 8-5, First Aid Training for Personnel in Basic Training.

A-4. TECHNICAL MANUALS.

TM 5-838-2, Medical Facilities Design: Army.

TM 8-215, Nuclear Handbook for Medical Service Personnel.

TM 8-230, Army Medical Department Handbook of Basic Nursing.

TM 8-285, Treatment of Chemical Agent Casualties and Conventional Military Chemical Injuries.

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A-5. TRAINING FILM/VIDEOTAPE.

TF 8-6035, Partners in Health.

TF 8-4876, Occupational Health Nursing in DA.

A-6. DEPARTMENT OF THE ARMY PAMPHLETS.

DA Pamphlet 385-1, Unit Safety Management.

DA Pamphlet 570-4, Manpower Procedures Handbook.

DA Pamphlet 570-557, Staffing Guide for US Army Medical Department Activities.

DA Pamphlet 600-8, Military Personnel Office Management and Administrative Procedures.

DA Pamphlet 600-17, A Commander's, Supervisor's, and Physician's Guide to Alcohol Abuse and Alcoholism.

A-7. TECHNICAL BULLETINS, MEDICAL.

TB MED 6, Occupational Health and Safety in Dental Clinics.

TB MED 81, Cold Injury.

TB MED 114, Immunization.

TB MED 267, Guidelines for Medical Evaluation of Applicants and Personnel In Army Nuclear Power Program.

TB MED 269, Carbon Monoxide: Symptoms, Etiology, Treatment and Prevention of Overexposure.

TB MED 279, Laser Radiation (to be republished as TB MED 524).

TB MED 282, Anticholinesterase Intoxication: Pathophysiology, Signs and Symptoms, and Management.

TB MED 288, Medical Problems of Man at High Terrestrial Elevations.

TB MED 291, Guidance for Inventory, Control and Accountability of Drugs and Injection Devices of Potential Abuse at Medical Treatment Facilities Worldwide.

TB MED 501, Noise and Conservation of Hearing.

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TB MED 502, Respiratory Protection Program.

TB MED 506, Occupational Vision.

TB MED 507, Prevention, Treatment and Control of Heat Injury.

TB MED 510, Waste Anesthetic Gases.

TB MED 521, Management and Control of Diagnostic X-Ray, Therapeutic X-Ray, and Gamma-Beam equipment.

TB MED 522, Control of Health Hazards from Radioactive Material Used in Self-Luminous Devices.

TB MED 523, Microwave Radiation.

TB MED 530, Food Service Sanitation.

TB MED 550, Evaluation and Control of Health Hazards in Spray Finishing Operations (to be published; currently USAEHA TG No. 023).

TB MED 551, Guidelines for the Design and Use of Chemical Laboratory Hoods (to be published; currently USAEHA TG No. 030).

TB MED 552, Evaluation and Control of Health Hazards of Elemental Mercury (to be published; currently USAEHA TG No. 028).

TB MED 553, Evaluation and Control of Health Hazards in Vapor Degreasing Operations (to be published; currently USAEHA TG No. 021).

TB MED 554, Evaluation and Control of Health Hazards in Open Surface Tank Operations (to be published; currently USAEHA TG No. 029).

TB MED 555, Evaluation and Control of Health Hazards in Nitroglycerine Operations (to be published; currently USAEHA TG No. 024).

A-8. DEPARTMENT OF DEFENSE MANUAL.

DOD 42701-M, DOD Construction Criteria Manual.

DOD 6055.5M, DOD Occupational Health Surveillance Manual, July 1981.

A-9. DOD INSTRUCTIONS.

DODI 6055.1, Department of Defense Occupational Safety and Health (OSH) Program.

DODI 6055.2, Personal Protective Equipment.

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DODI 6055.3, Hearing Conservation.

DODI 6055.5, Industrial Hygiene and Occupational Health.

A-10. PUBLIC LAWS.

Public Law (PL) 79-658, Health Programs for Government Employees, as amended [5 US Code (USC) 7901].

PL 91-596, Occupational Safety and Health Act of 1970, 29 December 1970, 29 USC 651 et seq.

PL 93-416, Federal Employees' Compensation Act (FECA).

PL 93-641, Preparation and Submission of Budget Estimates.

A-11. EXECUTIVE ORDER.

Executive Order 12196, Occupational Safety and Health Programs for Federal Employees, 26 February 1980.

A-12. CODE OF FEDERAL REGULATIONS.

Title 3, Code of Federal Regulations (CFR), 1979 ed., Presidential Documents Other Than Proclamations and Executive Orders, Subchapter 3, Administrative Orders, Radiation Protection Guidance to Federal Agencies for Diagnostic X-rays.

Title 10, CFR, Part 20, Standards for Protection Against Radiation.

Title 20, CFR, Chapter 1, Office of Workers' Compensation Programs, Department of Labor.

Title 29, CFR, Part 1910, Occupational Safety and Health Standards.

Title 29, CFR, Part 1910.20, Access to Employee Exposure and Medical Records.

Title 29, CFR, Part 1913, Rules of Agency Practice and Procedures Concerning OSHA Access to Employee Medical Records.

Title 29, CFR, Part 1960, Safety and Health Provisions for Federal Employees.

A-13. BUREAU OF BUDGET CIRCULAR.

Bureau of the Budget Circular No. A-11, Federal Employees Occupational Health Service Programs. 18 June 1965.

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A-14. GENERAL SERVICES ADMINISTRATION.

General Services Administration, Occupancy Guide, Federal Employee Health Units, September 1966.

A-15. OFFICE OF PERSONNEL MANAGEMENT REGULATIONS.

Office of Personnel Management, Handbook X-118, Qualification Standards for White Collar Positions Under The General Schedule, as amended.

OPM Handbook X-118C, Job Qualification System for Trades and Labor Occupations.

A-16. FEDERAL PERSONNEL MANUALS.

Federal Personnel Manual (FPM), Chapter 250, Personnel Management in Agencies.

FPM, Chapter 293, Personnel Records and Files.

FPM, Chapter 294, Availability of Official Information.

FPM, Chapter 339, Qualification Requirements (Medical).

FPM, Chapter 410, Training.

FPM Chapter 751, Appendix A, Disciplinary Procedures for Noncomplying Employees.

FPM, Chapter 792, Federal Employees Occupational Health Program.

FPM, Supplement 792-2, Alcoholism and Drug Abuse Programs.

FPM, Chapter 810, Injury Compensation.

FPM, Chapter 930, Appendix A, Physical Standards for Motor Vehicle Operators and Incidental Operators.

FPM, Supplement 990, Book 630, Absence and Leave.

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TS-27, Factor Evaluation System (FES), Position Classification Standards, General Introduction, Background, and Instructions, Section VII, Instructions for the Factor Evaluation System.

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TS-28, FES, Position Classification Standards, Nurse Series GS-610.

TS-34, FES, Position Classification Standards; Clerical Series.

TS-46, FES, Position Classification Standards, Industrial Hygiene Series.

A-17. CIVILIAN PERSONNEL REGULATIONS.

Civilian Personnel Regulation M1, Medical Examinations, 13 January 1960.

A-18. OFFICE OF WORKERS' COMPENSATION PROGRAMS.

OWCP Pamphlet CA-136, Federal Employees' Compensation Act Basic forms.

A-19. HSC SUPPLEMENTS.

HSC Supplement 1 to AR 1-35, Basic Policies and Principles for Interservice, Interdepartmental, and Interagency Support.

HSC Supplement 1 to AR 40-5, Health and Environment.

HSC Supplement 1 to AR 600-85, Alcohol and Drug Abuse Prevention and Control Program.

A-20. HSC REGULATIONS.

HSC Regulation 10-1, Organization and Functions Policy.

HSC Regulation 11-1, HSC Programming Guide.

HSC Regulation 11-4, HSC Operating Program - Preventive Medicine Guidelines for Implementation of a Preventive Medicine Program for MEDCEN/MEDDAC.

HSC Regulation 40-14, Medical Support - Nuclear and Chemical Personnel Reliability Program.

HSC Regulation 40-21, Health Service Regions and Health Service Areas.

HSC Regulation 690-11, Civilian Health Occupations Recruitment.

HSC Pamphlet 20-1, Accreditation Guide for Army Hospitals.

HSC Pamphlet 40-2, Occupational Health Program.

A-21. DEFENSE LOGISTICS AGENCY MANUAL.

DLAM 1000.1, Defense Logistics Agency Safety and Health Manual.

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A-22. USAEHA TECHNICAL GUIDES.

Appendices E, G, and H of The US Army Environmental Hygiene Agency Technical Guide No. 001, Medical Surveillance Guide (Guide for Job-Related Examinations).

TG No. 004, Medical Directives for Occupational Health Nurses.

TG No. 114, Guide for the Medical Surveillance of Pest Controllers.

TG No. 022, Industrial Hygiene Evaluation Guide.

TG No. 050, Guide to the Prevention and Control of Hospital-Associated Infections (out of print).

TG No. 026, Respiratory Protective Devices Approved By NIOSH.

TG No. 041, Personal Hearing Protective Devices: Fitting, Care, and Use.

TG No. 090, Radiation Protection Program, Department of the Army.

TG No. 125, Occupational Health Education Index.

USAEHA Selected References - Radiological Hygiene.

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Section II. Professional*

AAOHN, A Guide for the Preparation of a Manual of Policies and Procedures for the Occupational Health Service.

AAOHN, Guide for On-The-Job Orientation of the Occupational Health Nurse.

AAOHN, Guide to Interviewing and Counseling for the OH Nurse.

AAOHN, List of Publications, published and updated periodically.

AAOHN, Objectives of an Occupational Health Nursing Service.

AAOHN, Principles of Management-Nurse Relationship in Occupational Health.

AAOHN, Principles of Privileged Communications.

AAOHN, Principles of the Nurse-Physician Relationships in an Occupational Health Service.

AAOHN, Professional Liability Information.

AAOHN, Standards for Evaluating An Occupational Health Nursing Service.

AAOHN, Standards of Occupational Health Nursing Practice.

AAOHN, The Student Nurse in Occupational Health Nursing.

ACGIH, TLV's, Threshold Limit Values for Chemical Substances and Physical Agents in the Workroom Environment.⁴

AHS, Videotape Catalog, Continuing Medical Education and Instruction, Academy of Health Science.

AMA, Publications In Occupational Health, published and updated periodically.

AMA, Scope, Objectives and Functions of Occupational Health Programs.

AMA, Guides to the Evaluation of Permanent Impairment.

AMA, Guide to Development of an Industrial Medical Records System.

* See page A-14 for footnotes.

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American Academy of Orthopedic Surgeons, Emergency Care and Transportation of the-Sick and Injured, 430 North Michigan Ave, Chicago, IL 60611.

ANA, Guide for the Development of a Manual for an Employee Health Program.

ANA, Programmed Learning Sources.

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AOMA, Organization and Operation of an Occupational Health Program.

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Casarett, Louis J. and John Doull, (Eds.), Toxicology⁴, Macmillan Publishing Co., Inc., Third Ave., New York, NY 10022. 1975.

Ederma, Arvo B., An Administrative Guide For Federal Occupational Health Units, USDHHS, DHHS Publication No. (HSA)-77-2033.

Gosselin, Robert E., et al., Clinical Toxicology of Commercial Products, The Williams and Wilkins Co., 428 E. Preston St., Baltimore, MO 21202. 1976.

Hamilton, Alice and Harriet Hardy, Industrial Toxicology³, Publishing Sciences Group, Inc., 162 Great Road, Acton, MA 01720. 1974.

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Lee, Jane, The New Nurse in Industry⁴, US Government Printing Office, Washington, DC 20402. 1978

Lilienfeld, Abraham M. and D. E. Lilienfeld, Foundations of Epidemiology, Oxford University Press, New York, Second Ed.,

Mahoney, E. A., L. Verdisco, and L. Shortridge, How To Collect And Record a Health History, J. B. Lippincott Co., Philadelphia.

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McLean, Alan A., Ed., Work Stress, Addison Wesley Pub., Reading, MA.

NIOSH, Criteria Documents.

NIOSH, Educational Resource Centers: Schedule of Courses, published semiannually.

NIOSH, Occupational Safety and Health Directory.

NIOSH, Pocket Guide to Chemical Hazards⁴, DHHS (NIOSH) Pub No. 78-210.

NIOSH, Publications Catalog, published annually.

DHHS (NIOSH) Publication No. 81-123, Occupational Health Guidelines for Chemical Hazards, January 1981.

Occupational Safety and Health Reporter, Bureau of National Affairs, 1231 25th Street. N.W., Washington, DC 20037 (published weekly).

Olishifski, J. B. and E. R. Harford, (Ed's.), Industrial Noise and Hearing Conservation, National Safety Council, Chicago, Il. 1975.

OSHA, Record Keeping Requirements⁴, US Department of Labor, Washington, DC.

OTSG, Index to Official Publications Pertaining to Army Preventive Medicine, Preventive Medicine Division, Directorate Of Professional Service, OTSG, DA, Washington, DC 20314.

Sax, N. Irving (Ed.), Dangerous Properties of Industrial Materials², Van Nostrand Reinhold Co., 135 W. 50th St., New York, NY 10020, Fifth Ed. 1979.

Schilling, R. S. F. (Ed.), Occupational Health Practice², Butterworth and Co., Ltd., Toronto, Canada. 1973.

Suskind, Raymond R., et al, Standards, Interpretations, and Audit Criteria for Performance of Occupational Health Programs, Department of Environmental Health, Kettering Laboratory, University of Cincinnati for Occupational Health Institute, 150 North Wacker Drive, Chicago, IL 60606
(Nursing section published in Occupational Health Nursing, April 1977.)
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US*Department of Health and Human Services (formerly HEW), The Industrial Environment: Its Evaluation and Control³, US Government Printing Office, Washington, DC 20402. 1974

US Department of Health and Human Services, Occupational Diseases, A Guide to Their Recognition⁴, US Government Printing Office, Washington, DC Revised Edition. 1977.

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JOURNALS

Archives of Environmental Health², Heldref Publications, 4000 Albemarle St, N.W., Washington, DC 20016.

Job Safety and Health², US Department of Labor, Occupational Safety and Health Administration (available from Superintendent of Documents).

Journal of Occupational Medicine², American Occupational Medical Assn.

Occupational Health, Bailliere Tindall, 35 Red Lion Square, London, WC1R 4SG, England.

Occupational Health Nursing², AAOHN, Charles B. Slack, Inc., Publisher, 6900 Grove Rd, Thorofare, NJ 08086.

Occupational Health and Safety², Medical Publications, Inc., 4901 Bosque Blvd, Waco, TX 76710.

¹ See section III for mailing addresses.

² Suggested reference. Procurement for the Occupational health clinic should be based on need in accordance with the type of installation operations and potential health hazards, as well as the availability of the reference at other locations at the installation.

³ Recommended if an industrial hygienist or an industrial hygiene technician is assigned to the Occupational health program.

⁴ Recommended minimum reference material which should be available in the Occupational health clinic for ready use by Occupational health personnel.

Section III. Addresses of Reference Resources

Academy of Health Sciences, Fort Sam Houston, TX 78234

American Association of Occupational Health Nurses, Inc., 575 Lexington Ave,
New York, NY 10022

American Conference of Governmental Industrial Hygienists, P.O. Box 1937,
Cincinnati, OH 45201

American Medical Association, 535 North Dearborn St, Chicago, IL 60610

American National Red Cross - reference local Red Cross Chapter

American Nurses' Association, Inc., 2420 Pershing Road, Kansas City, MO
64108

American Occupational Medical Association, Inc., 150 N. Wacker Drive,
Chicago, IL 60606

National Institute for Occupational Safety and Health, Publications
Dissemination, DTS, 4676 Columbia Parkway, Cincinnati, OH 45226

Occupational Safety and Health Administration, Publications Office, Room
S1212, Frances Perkins Building, Third Street and Constitution Ave, N.W.,
Washington, DC 20210

Superintendent of Documents, US Government Printing Office, Washington, DC
20402

APPENDIX B

ABBREVIATIONS

AAOHN	American Association of Occupational Health Nurses, Inc.
ACIF	Army Central Insurance Fund
ADAC	Army Drug Abuse Control
ADAPCP	Alcohol and Drug Abuse Prevention and Control Program
ADP	Automatic Data Processing
AEHA	Army Environmental Hygiene Agency
AF	Appropriated Fund
ANA	American Nurses Association
ANRC	American National Red Cross
ANSI	American National Standards Institute
AMA	American Medical Association
AMEDD	Army Medical Department
AMOSIST	Enlisted Medical Corpsmen Working in Acute Minor Illness Clinic (AR 40-48)
AOHHI	Army Occupational Health, Hazard Inventory
AOMA	American Occupational Medical Association
ARD	Acute respiratory disease
ASAP	As soon as possible
BVM	Bag Valve Mask
C	Chief
CDC	Centers for Disease Control, DHHS
CDR	Commander
CFR	Code of Federal Regulations
Chap	Chapter
CHN	Community Health Nurse
CIVPERSIN	Civilian Personnel Information Systems
CMS	Centralized Materiel Service
COEMIS	Corps of Engineers Management Information Systems
CONUS	Continental United States
CPO	Civilian Personnel Office
CPR	Cardio-Pulmonary resuscitation
CSA	Chief of Staff, US Army
CSC	Civil Service Commission
CY	Calendar Year
DA	Department of Army
DARCOM	US Army Materiel Development and Readiness Command
DASG	DA Surgeon General
DCSPA	Deputy Chief of Staff for Professional Activities
DOD	Department of Defense
DF	Disposition Form
DGF	Demographic and Geographic Factors
DHHS	Department of Health and Human Services
DLA	Defense Logistics Agency

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DLAM	Defense Logistics Agency Manual
DOD	Department of Defense
DODI	DOD Instructions
DPCCM	Department of Primary Care and Community Medicine
ENT	Ear, Nose, and Throat
ER	Emergency Room
ESO	Environmental Science Officer
FECA	Federal Employees Compensation Act
FES	Factor Evaluation System
FORSCOM	US Army Forces Command
FPM	Federal Personnel Manual
FY	Fiscal Year
GOCO	Government-owned, contractor-operated
GS	General Schedule Employees
GSA	General Services Administration
HEW	Department of Health, Education, and Welfare
HHS	Department of Health and Human Services
HREC	Health Record
HSA	Health Service Area
HSC	US Army Health Services Command
Hdq	Headquarters
IAW	In accordance with
ICU	Intensive Care Unit
LMD	Medical Doctor/Personal Physician
LOHHI	Local Occupational Health Hazard Inventory
MACOM	Major Command
MDW	Military District of Washington
MEDCEN	US Army Medical Center
MEDDAC	US Army Medical Department Activity
MEDLINE	Medical Literature On-Line
MILPO	Military Personnel Office
MISO	Management Information Systems Office
MOS	Military Occupational Specialty
MOU	Memorandum of Understanding
MTF	Medical Treatment Facility
NAF	Nonappropriated Fund
NAFI	NAF Instrumentality
NIOSH	National Institute for Occupational Safety and Health
NLT	Not later than
OB/GYN	Obstetrics/gynecology
OCE	Office Corps of Engineers
OH	Occupational Health
OHC	Occupational Health Clinic
OHH	Occupational Health Hazard
OHN	Occupational Health Nurse
OHMD	Occupational Health Physician
OHMIS	Occupational Health Management Information System

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OHP	Occupational Health Program
OHS	Occupational Health Service
OHT	Occupational Health Technician
OMF	Official Medical Folder
OPC	Outpatient Clinic
OPM	Office of Personnel Management
OPF	Official Personnel Folder
OSHA	Occupational Safety and Health Act of 1970
OTR	Outpatient Treatment Record
OTSG	Office of The Surgeon General
OWCP	Office of Workers' Compensation Programs
PA	Physician Assistants
PAD	Patient Administration
PAO	Public Affairs Office
PBF	Potentially Beneficial Factors
PHS	United States Public Health Service
PIO	Public Information Office
PL	Public Law
PMA	Preventive Medicine Activity
PMO	Preventive Medicine Officer
POT	Plans, Operations and Training
POV	Privately owned motor vehicle
PVNTMED	Preventive Medicine
Reg	Regulation
RPO	Radiation Protection Officer
SCIPMIS	Standard Civilian Personnel Management Information System
SHM	Safety and Health Manager
SIDPERS	Standard Installation/Division Personnel System
SKAP	Skills, Knowledge, Ability, and Personal Characteristics
SOP	Standing Operating Procedure
SSI	Specialty Skill Identifier
SSN	Social Security Number
STARCIPS	Standard Army Civilian Personnel Systems
SO	Safety Office
TAB	Therapeutics Advisory Board
TBC	Tuberculosis
TDY	Temporary Duty Travel
TMC	Troop Medical Clinic
TOE	Table of Organization and Equipment
TRADOC	US Army Training and Doctrine Command
USACH	US Army Community Hospital
USAEHA	US Army Environmental Hygiene Agency
USAHC	US Army Health Clinic
USC	United States Code
GPO	US Government Printing Office
USPHS	United States Public Health Service
WG	Wage Grade Employees

APPENDIX C

GLOSSARY

EMPLOYEES.

Contractor employees. Those persons hired by firms that provide goods or services to the Army under contract.

Federal civilian employees (AF). All career, career-conditional, and temporary Department of Army civilian employees subject to OPM regulations, paid from appropriated funds and covered by the Federal Employees' Compensation Act for occupational injuries and illnesses. Foreign national civilian employees of DA are included.

Military personnel. All Army personnel on active duty, Army Reserve and Army National Guard personnel on active duty or drill status, Army Military Academy cadets, and Reserve Officer Training Corps cadets when engaged in directed training.

Nonappropriated Fund (NAF) civilian employees. All civilian personnel employed by Army activities that are not supported by appropriated funds and whose employees are not covered by FECA.

Volunteers. Persons who provide services to the Army without pay. Usually, they are trained by, and their services are arranged through, a local unit of the American National Red Cross.

ERGONOMICS. The application of biological and engineering data to problems relating to the mutual adjustment of man, the machine, and the work environment, particularly in terms of physiological, psychological, and technological capabilities and requirements.

GOALS AND OBJECTIVES.

Goal. A broad general statement of the overall end purpose of a program. It does not stipulate a time period or numeric standards.

Objective. A statement of desired end results to be achieved within a given period of time. It is related to a particular problem or need, is realistic, measurable, precisely stated, and specifies how much, of what, affecting whom, will be made to happen, by when.

HEALTH EVALUATION.

Job-related medical surveillance. Limited or complete evaluation of the health status of an individual specific to the health hazards or physical stresses to which s/he may be exposed in the work assignment. The evaluation may be conducted preplacement, periodically during period of assignment to the job, on termination of assignment, or when indicated by special problems or particular potential or actual exposures.

Nursing health appraisal. A health maintenance evaluation conducted by a nurse IAW protocols established in coordination with the physician. In addition to the age-sex determined health factors, the scope of the evaluation is based on the nurse's specific capabilities and available testing resources. Nurses qualified and credentialed to perform specific physical assessment procedures will be able to include those elements of the evaluation when appropriate.

Specific disease screening program. A health maintenance evaluation specific to one or more disease entities, usually offered on a one-time basis for each disease. However, a series of programs may be offered over a period of years, rotating the type disease screened for in each program.

Voluntary health maintenance evaluation. Limited or complete evaluation of the general health status of an individual to identify potential health problems and recommend action to prevent or control adverse affects of such problems. Such evaluations may be performed as physician conducted examinations, nursing health appraisals, multiphasic disease screening, or one or more specific disease screening programs. They may be offered as a one-time program or as an ongoing program with the frequency and scope determined by the age and the related age-sex associated anticipated health problems.

ILLNESS AND INJURY.

First aid. One time treatment and subsequent observation of minor cuts, burns, etc. which do not require medical care, even though the care may be performed by a physician.

Medical treatment. Conditions requiring treatment by a physician or by professional personnel under the orders of the physician.

Occupational illness (OSHA). Any abnormal condition or disorder, other than one resulting from an occupational injury, caused by exposure to environmental factors associated with employment to include physical, chemical, or biological agents involved in the work assignment. It includes acute and chronic illnesses which may be caused by inhalation, absorption, ingestion, or direct contact and/or by repeated trauma, such as noise-induced hearing loss or bursitis. OSHA categories of occupational illnesses are defined as follows:

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a. Occupational skin diseases or disorders. Contact dermatitis, eczema, or rash caused by work exposure to primary irritants and sensitizers, caustic chemicals, or poisonous plants (e.g., oil acne; chrome ulcers; chemical burns or inflammations; etc.).

b. Dust diseases of the lungs (pneumoconioses). Lung disorders caused by work exposure to dusts, fibers, particulates, etc., such as silicosis, asbestosis, coal worker's pneumoconiosis, byssinosis, siderosis, and other pneumoconioses.

c. Respiratory conditions due to toxic agents. Disorders caused by exposure to toxic fumes, gases, vapors, etc., in the work place (e.g., metal fume fever, pneumonitis, pharyngitis, rhinitis or acute lung congestion, farmer's lung; etc.)

d. Poisoning (systemic effect of toxic materials). Includes effects of absorption of toxic substance present in the work place (e.g., poisoning by lead, mercury, cadmium, arsenic, or other metals; poisoning by carbon monoxide, hydrogen sulfide, or other gases; poisoning by benzol, carbon tetrachloride, or other organic solvents; poisoning by insecticide sprays such as parathion, lead arsenate; poisoning by other chemicals such as formaldehyde. plastics. and resins; etc.).

e. Disorders due to physical agents (other than toxic materials). Conditions caused by overexposure in the work situation to heat, cold, motion, atmospheric pressure, etc. (e.g., heatstroke, sunstroke, heat exhaustion, and other effects of environmental heat; freezing, frostbite, and effects of exposure to low temperatures; caisson disease; effects of ionizing radiation (isotopes, x-rays, radium), effects of nonionizing radiation (welding flash, ultraviolet rays, microwaves, sunburn); motion sickness; etc.).

f. Disorders associated with repeated trauma. Includes noise-induced hearing loss; synovitis, tenosynovitis, and bursitis; Raynaud's phenomena; and other conditions due to repeated motion, vibration, or pressure.

g. All other occupational illnesses. Conditions caused by work exposure to infectious, carcinogenic, or other agents not included above (e.g., anthrax, brucellosis, infectious hepatitis, malignant and benign tumors, food poisoning, histoplasmosis, coccidioidomycosis, etc.

Occupational illness (OWCP). A disability resulting from repeated trauma or exposure and taking more than one work shift for symptoms to develop, such as a hypersensitivity dermatitis due to repeated exposure to a toxic agent.

Occupational injury (OSHA). Any traumatic injury, such as a cut, fracture, which results from a work accident or from an exposure involving a single incident in the work environment. This includes conditions resulting from bites, such as from animals, insects, or snakes, or from one-time exposure to chemicals, such as a chemical splash of the eye.

Occupational injury (OWCP). Disability resulting from a one-time trauma and/or occurring within one work shift, such as a chemical burn caused by a one-time spill. Note: Diagnosis of occupational injury or illness is based on a detailed history of current and past work practices and environments; the nature and severity of exposure; signs, symptoms, and laboratory or clinical evidence compatible with the exposure.

On Duty. For the purposes of the occupational health program, personnel (civilian and military) are on duty when they are:

1. Physically present at any location where they are to perform officially assigned work, including activities and locations incidental to normal work that occur during work days, such as lunch and coffee breaks, and all activities aboard vessels.
2. Being transported by Federal Government or commercial conveyance to perform officially assigned work, including reimbursable temporary duty travel in privately owned motor vehicles.
3. In travel status because of temporary duty but only during period for which reimbursable expenses are authorized.
4. Participating in officially sponsored sports and physical training activities.

Note: For military personnel. Reporting of occupational injuries and illnesses is limited to those that are incurred when the individual is "on duty" and are the result of the performance of the duty assignment, (e.g., injuries or illnesses incurred while working in the motor pool, performing field training exercises, etc.). This does not include and should not be confused with "line of duty" conditions such as acute respiratory illnesses of basic training, etc. or incurred during off-duty hours or while involved in noncompulsory Army sponsored recreational activities.

INDUSTRIAL HYGIENE. The recognition, evaluation, and control of those environmental factors or stresses, arising in or from the work place, which may cause sickness, impaired health and well-being, or significant discomfort and inefficiency among workers.

MEDICAL AUTHORITY. Refers to the Unit Surgeon, Command Chief Surgeon, MEDDAC/MEDCEN Commander, and the Director of Health Services or his representatives responsible for provision of medical support at the unit, col,,,and, or installation concerned.

OCCUPATIONAL HEALTH PRACTICE. The application of preventive medicine principles and medical and nursing practice to conserve, promote, and restore the health and effectiveness of workers (military and civilian) at the place of employment.

APPENDIX D

DEPARTMENT OF ARMY ADMINISTRATIVE ORGANIZATION AND CHANNELS FOR
THE OCCUPATIONAL HEALTH PROGRAM

D-1. PURPOSE AND SCOPE. This appendix provides information relative to the organizational structure of the Army specifically related to occupational health. It focuses primarily on the Army Medical Department (AR 10-5) and, thus, presents an overview of the DOD/DA organization for safety and occupational health. See figure D-1.

D-2. MAJOR DA ELEMENTS. Organization and Responsibilities.

a. Office Assistant Secretary of the Army (Installations, Logistics and Financial Management), Hq, Department of the Army. The Deputy for Environment, Safety, and Occupational Health is located in this office. The office is responsible for providing executive leadership at the Army secretariat level to insure timely compliance with environment, safety, and occupational health requirements and has oversight and monitoring responsibility for implementation and operation of the DA occupational health program. Army policies and programs for environment, safety, and occupational health are formulated and developed at this level.

b. Office of The Surgeon General (OTSG), Hq, Department of the Army. The OTSG is a special staff element of DA. The Surgeon General is responsible for development, policy direction, organization, and overall management of an integrated health care system that provides health services for the Army and for other agencies and organizations (AR 10-5). Occupational health is within the broad scope of these health services. The Surgeon General has delegated responsibility for occupational health to the occupational health consultants located in the Preventive Medicine Consultants Division of the Professional Services Directorate. Policy making and standard setting are performed at this level.

c. US Army Health Services Command.

(1) General. HSC is directed and supervised by the Chief of Staff, US Army (CSA). HSC commands and manages all health care services and resources for the Army within continental United States (CONUS), Alaska, Panama, Puerto Rico, Hawaii, Johnston Island, Guam, and Trust Territories of Pacific. HSC also provides health services for other government agencies and organizations when directed by CSA (AR 10-43). At HSC, responsibility for occupational health is assigned to the PVNTMED Division of the Deputy Chief of Staff for Professional Activities. Interpretation of Army OH policies and further development of criteria and procedures applicable to areas within the scope of the HSC area are developed at this level.

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(2) USA Medical Department Activities/USA Medical Centers. Commanders of HSC MEDDAC/MEDCEN are responsible for providing occupational health services within the geographic areas of their responsibilities (HSC Reg 10-1). OHP technical guidance is the responsibility of the respective PVNTMED Activity. Clinical responsibility for support of the occupational health program is usually that of DPCCM. All DA clinics and hospital elements are assigned to either a MEDDAC or MEDCEN whether or not they are collocated with a MEDDAC/MEDCEN headquarters.

(3) US Army Environmental Hygiene Agency. USAEHA, an HSC element, provides worldwide support to the Army's PVNTMED program (chap 12, HSC Reg 10-1). Consultants are available within USAEHA in all technical aspects of occupational health. Selected laboratory and other support services are provided. In addition to the main location at Aberdeen Proving Ground, MD, Regional Divisions are located at Fitzsimons Army Medical Center, CO; Fort McPherson, GA; and Fort Meade, MD.

d. Other Major Commands. With few exceptions, Army MTF are located as tenants on installations controlled by other commands. Primarily, these major commands are: US Army Forces Command (FORSCOM), Training and Doctrine Command (TRADOC), and US Army Materiel Development and Readiness Command (DARCOM). Agreements have been written by most of these commands with HSC to clearly define responsibilities of each Command. Pertinent excerpts from the memorandums of understanding between the Commander, HSC, and the Commanders of FORSCOM (AR 10-42); TRADOC (AR 10-41), and DARCOM (AR 10-11) are found in appendix Y. These MOU define general support provided by HSC tenants to TRADOC, FORSCOM, and DARCOM installations. Occupational health services are included in this medical support. The Surgeons assigned to the MACOM review health needs (including OH) peculiar to their respective MACOM; advise MACOM commanders of health requirements, problems, and actions needed; assist in development of MACOM policies with health implications; and establish liaison between the MACOM and medical personnel at various levels (OTSG, HSC, installation).

e. Outside Continental United States. Command and control of health facilities and resources and further definition of OTSG policies in Europe, Korea, and Japan are provided by the Seventh Medical Command, Eighth US Army Surgeon, and US Army Japan Surgeon, respectively. MEDDAC's are organized similarly to those in the HSC area [para c(2), above].

D-3. INSTALLATION ORGANIZATION AND RESOURCES.

a. Installation Command Channels.

(1) Installation commander. The installation commander is responsible for all aspects of health and safety within his command. This includes support of the PVNTMED (and OH) program (AR 40-5) and the safety program (AR 385-10).

(2) Director of Health Services. The Commander or Chief of the MTF also serves on the installation commanders staff as DHS. As such he functions as a member of the installation, rather than as a tenant, and is the medical authority responsible for establishing and operating the PVNTMED program and providing consultation and guidance on PVNTMED matters. The functions of the DHS are described in AR 10-43 and HSC Reg 10-1.

(3) Safety. Executive Order 12196 applies the Occupational Safety and Health Act to Federal Agencies and civilian employees. DOD directives extend that to include military personnel, except for military unique operations. Overall responsibility for occupational safety and health within the Army is assigned to DA Safety, a component of the DCSPR staff. The Army Surgeon General maintains responsibility for health and medical aspects of the program. In order to meet the objectives of OSHA, Executive Orders, and DODI's; to insure that all aspects of the occupational health and safety program are included; and to avoid duplication of effort, close coordination and cooperation between safety and health personnel is required at all Army levels. Safety responsibilities are defined in AR 385-10.

(4) Other Installation Activities.

(a) Many other installation activities provide support to the occupational health program. Among these are the CPO, Military Personnel Office, MISO, PAO, Alcohol and Drug Abuse Council, operating directorates, supervisors, and union representatives. Some of these resources have assigned responsibilities specific to occupational health. While others may not have such stated responsibilities, they are of great value in supporting the occupational health program (reference para 4-8).

(b) Installation support of administrative aspects of the OHP is defined in the MACOM MOU (app V). Of particular interest is assistance related to facility space, maintenance, and repair; personnel support for OH staff and program actions; transportation (of staff or patients); nonmedical supplies; management information system; ADAPCP program; and public affairs and information support.

APPENDIX E

RECORDS AND REPORTS

Section I. Regulations/Directives Pertinent to OHS Records/Reports

AR 40-2	Army Medical Treatment Facilities - General Administration (para 1-6 and Chap 3).
AR 40-5	Preventive Medicine (para 4-10 and Chap t)
AR 40-14	Occupational Exposure to Ionizing Radiation, Control and Recording Procedures
AR 40-62	Standard Policies, Definitions and Data Presentations Relating to Fixed Medical Treatment facilities and Patient Accountability (para 4)
AR 40-66	Medical Record and Quality Assurance Administration
AR 40-332	Preparation of DD Forms 7 and 7A for Billing Purposes
AR 40-418	Medical Statistical Reporting
AR 50-5	Nuclear Surety Program (paras 3-10, 3-14, 3-15, 3-18, 3-19)
AR 50-6	Chemical Surety Program (paras 3-22, 3-24, 3-27, 3-28)
AR 230-2	Non Appropriated Fund and Related Activities Personnel Policies and Procedures (paras 2-8e, f; Chap 18)
AR 230-16	NAF and Related Activities Risk Management Program (Chap 13, Workers' Compensation)
AR 310-1	Publications, Blank Forms, and Printing Management (Chap 4) (paras 4-6, 4-25, 4-18)
AR 340-18-9	Maintenance and Disposition of Medical Functional Files (File Nos. 903, 906, 919, 923, etc.)
AR 340-21-9	The Army Privacy Program-Systems Notices Exemption Rules for Medical Functions (91.01)
AR 385-40	Accident Reporting and Records (Chap 4, etc.)

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AR 600-6	Individual Sick Slip (DD Form 689)
HSC Pam 40-2	Occupational Health Program (para 5)
TB MED 501	Hearing Conservation Program Records and Reports (DD Forms 2214, 2215, 2216, and 2217)
DODI 6055.5	Industrial Hygiene and Occupational Health (para 6)
Title 29 CFR 1910.20	Access to Employee Medical Records
Title 29 CFR 1960	Basic Program Elements for Federal Employee Occupational Safety and Health Programs (sub part J.)
FPM Chapter 293	Personnel Records and Files (para 1-3f(3), 3-3, and A-1(12))
FPM Chapter 339	Qualification Requirements (para 4)
FPM Chapter 930	Programs for Specific Positions and Examinations (Appendix A, Physical Standards for Motor Vehicle Operators and Incidental Operators)

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Section II. Recommended/Required Standard Forms for
Occupational Health Services

E-1. MEDICAL RECORDS.

SF 78	USCSC/OPM, Certificate of Medical Examination (Civilian)
SF 88	Report of Medical Examination (Military)
SF 93	Report of Medical History
SF 502	Narrative Summary
SF 507	Clinical Record - Report on or Continuation of SF
SF 513	Clinical Record-Consultation Sheet
SF 545	Clinical Record - Laboratory Display
SF 546-557	Specific Laboratory Test Report Forms
SF 519	Clinical Record - Radiographic Report
SF 520	Clinical Record - Electrocardiographic Record
SF 600	Health Record - Chronological Record of Medical Care
SF 601	Health Record - Immunization Record
HSC Form 79	Master Problem List
DD Form 1141	Record of Occupational Exposure to Ionizing Radiation
DD Form 1952	Film Badge Application and Record of Occupational Exposure
DD Form 2005	Privacy Act Statement, Health Care Records
DD Form 2215	Reference Audiogram
DD Form 2216	Hearing Conservation Data
DA Form 3437	Nonappropriated Funds, Certificate of Medical Examination
DA Form 3444 and thru 3444-9	Terminal Digit File for Treatment Record
DA Form 4515	Personnel Reliability Program Record Identifier
DA Form 3180, 3180A	Personnel Screening and Evaluation Record

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DA Form 4700	Medical Record - Supplemental Medical Data
SF 217	Medical Report (Epilepsy)
CSC form 740	Eye Examination
CSC Form 3684	Medical Report (Diabetes Mellitus)
CSC Form 4434	Medical Report (Pulmonary Tuberculosis)
Unnumbered	Visual Performance Profile Card

E-2. NONMEDICAL FORMS WHICH MAY BE FILED IN MEDICAL RECORD.

SF 47	Physical Fitness Inquiry for Motor Vehicle Operators
SF 177	Statement of Physical Ability to Perform Light Duty
DA 3666	Nonappropriated Funds, Statement of Physical Ability for Light Duty Work

E-3. COMPENSATION FORMS (FPM CHAP 810).

Pam CA-136	Federal Employees' Compensation Act Basic Forms
CA-1	Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation
CA-2	Federal Employee's Notice of Occupational Disease and Claim for Compensation
CA-2A	Notice of Employee's Recurrence of Disability and Claim for Pay/Compensation
CA-3	Report of Termination of Disability and/or Payment
CA-4	Claim for Compensation on Account of Occupational Disease
CA-7	Claim for Compensation on Account of Traumatic Injury
CA-8	Claim for Continuing Compensation on Account of Disability
CA-16	Request for Examination and/or Treatment
CA-17	Duty Status Report
CA-20	Attending Physician's Report
CA-20a	Attending Physician's Supplemental Report

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E-4. ADMINISTRATIVE FORMS.

DD Forms 7 & 7A	Report of Treatment Furnished Pay Patients
DD 173	Special Telegraphic Report of Selected Diseases
DD 689	Individual Sick Slip
DD 877	Request for Medical/Dental Records of Information
DD Form 1313	Material Safety Data Sheet
DO 2214	Noise Survey
DD 2217	Biological Audiometer Check
DA Form 1167	Request for Approval of Form
Unnumbered	Patient's Recording Card
DA 2789R	Medical Summary Report [Med 302(R2)]
DA 3075	Occupational Health Daily Log
DA 3076	Army Occupational Health Report
DA 3365	Authorization for Medical Warning Tags
DA 3949	Controlled Substances Record
DA 3949-1	Controlled Substances Inventory
DA 4254-R	Request for Private Medical Information
DA XXXX-R	Authorization for Disclosure of Information
DA 4410-Ps	Disclosure/Accounting Record
DA Label 162	Emergency Medical Identification Symbol
HSC Form 403R	Local Occupational Health Hazard Inventory (LOHHI)
HSC Form 403a R	Army Occupational Health Hazards Inventory (LOHHI II)
DLA 1012	Compiled Daily and Monthly Log of Occupational Health Services
DLA 1013	Occupational Health Report
OSHA NO. 100F	Log of Federal Occupational Injuries and Illness

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Section III. Examples of Selected OH Record and Report Forms

Figure	Form	Title
E-1	HSC 79	Master Problem List
E-2	SF 78	Certificate of Medical Examination
E-3	SF 93	Report of Medical History
E-4	DA 3437	Certificate of Medical Examination (NAF)
E-5	SF 177	Statement of Physical Ability for Light Duty Work
E-6	DA 3666	Statement of Physical Ability for Light Duty Work (NAF)
E-7	SF 600	Chronological Record of Medical Care
E-8	B&L Catalogue No. 71-21-62	Visual Performance Profile Card
E-9	DD 1141	Record of Occupational Exposure to Ionizing Radiation
E-10	DD 689	Individual Sick Slip
E-11	DA 4254-R	Request for Private Medical Information
E-12	DA XXXX-R	Authorization for Disclosure of Information
E-13	DA 3076	Army Occupational Health Report
E-14	DA 4700	Medical Record Supplemental Medical Data
E-15	DD 2005	Privacy Act Statement - Health Care Records
E-16	SF 513	Consultation Sheet
E-17	DA 3949-1	Controlled Substances Inventory
E-18	DA 3949	Controlled Substances Record
E-19	DA 3075	Occupational Health Daily Log
E-20	OSHA No. 100F	Log of Federal Occupational Injuries and Illnesses

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<p>UNITED STATES CIVIL SERVICE COMMISSION CERTIFICATE OF MEDICAL EXAMINATION</p>		<p>Form Approved Budget Bureau No. 50-R0073</p>
<p>Part A. TO BE COMPLETED BY APPLICANT OR EMPLOYEE (typewrite or print in ink)</p>		
<p>1. NAME (last, first, middle) Doe, George A.</p>	<p>2. SOCIAL SECURITY ACCOUNT NO. 220 12 3231</p>	<p>3. SEX <input checked="" type="checkbox"/> MALE <input type="checkbox"/> FEMALE</p> <p>4. DATE OF BIRTH 28 March 1924</p>
<p>5. DO YOU HAVE ANY MEDICAL DISORDER OR PHYSICAL IMPAIRMENT WHICH WOULD INTERFERE IN ANY WAY WITH THE FULL PERFORMANCE OF THE DUTIES SHOWN BELOW? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO (If your answer is "YES" explain fully to the physician performing the examination)</p>		<p>6. I CERTIFY THAT ALL THE INFORMATION GIVEN BY ME IN CONNECTION WITH THIS EXAMINATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF. <i>George A. Doe</i> (signature of applicant)</p>
<p>Part B. TO BE COMPLETED BEFORE EXAMINATION BY APPOINTING OFFICER</p>		
<p>1. PURPOSE OF EXAMINATION <input type="checkbox"/> PREAPPOINTMENT <input checked="" type="checkbox"/> OTHER (specify) Annual physical</p>	<p>2. POSITION TITLE Guard</p>	
<p>3. BRIEF DESCRIPTION OF WHAT POSITION REQUIRES EMPLOYEE TO DO See attached job description. This employee will be required to meet the requirements of the Chemical Suitability and Reliability Program.</p>		
<p>4. Circle the number preceding each functional requirement and each environmental factor essential to the duties of this position. List any additional essential factors in the blank spaces. Also, if the position involves law enforcement, air traffic control, or fire fighting, attach the specific medical standards for the information of the examining physician.</p>		
<p>A. FUNCTIONAL REQUIREMENTS</p>		
<p>1. Heavy lifting, 45 pounds and over 2. Moderate lifting, 15-44 pounds 3. Light lifting, under 15 pounds 4. Heavy carrying, 45 pounds and over 5. Moderate carrying, 15-44 pounds 6. Light carrying, under 15 pounds 7. Straight pulling (hours) 8. Pulling hand over hand (hours) 9. Pushing (hours) 10. Reaching above shoulder 11. Use of fingers 12. Both hands required 13. Walking (hours) 14. Standing (hours)</p>	<p>15. Crawling (hours) 16. Kneeling (hours) 17. Repeated bending (hours) 18. Climbing, ladders only (hours) 19. Climbing, usual ladders and arms 20. Both legs required 21. Operation of cranes, truck, tractor, or motor vehicle 22. Ability for rapid mental and muscular coordination simultaneously 23. Ability to use and desirability of using firearms 24. Near vision correctable at 13" to 16" to Snager 1 to 4 27. Extended period of surveillance of terrain (geographical features 8 hours)</p>	<p>25. Far vision correctable in one eye to 20/20 and to 20/40 in the other 26. Far vision correctable in one eye to 20/50 and to 20/100 in the other 27. Specific visual requirement (specify) 28. Both eyes required 29. Depth perception 30. Ability to distinguish basic colors 31. Ability to distinguish shades of colors 32. Hearing (aid permitted) 33. Hearing without aid 34. Specific hearing requirements (specify) Other (specify) 34. Both ears-ability to distinguish source of sounds in darkness. No restrictions on use of firearms or radios.</p>
<p>B. ENVIRONMENTAL FACTORS</p>		
<p>1. Outside 2. Outside and inside 3. Excessive heat 4. Excessive cold 5. Excessive humidity 6. Excessive dampness or chilling 7. Dry atmospheric conditions 8. Excessive noise, intermittent 9. Constant noise 10. Dust</p>	<p>11. Silica, asbestos, etc. 12. Fumes, smoke, or gases 13. Solvents (degreasing agents) 14. Grease and oils 15. Radiant energy 16. Electrical energy 17. Slippery or uneven walking surfaces 18. Working around machinery with moving parts 19. Working around moving objects or vehicles</p>	<p>20. Working on ladders or scaffolding 21. Working below ground 22. Unusual fatigue factors (specify) 23. Working with hands in water 24. Explosives 25. Vibration 26. Working closely with others 27. Working alone 28. Protracted or irregular hours of work 29. Other (specify) 22. Running 100 yds with emergency equip (approx 50 lbs)</p>
<p>Part C. TO BE COMPLETED BY EXAMINING PHYSICIAN</p>		
<p>1. EXAMINING PHYSICIAN'S NAME (type or print) S. H. WILLIAMS, M.D.</p> <p>2. ADDRESS (including ZIP Code) ABD Army Depot XYZ, Maryland 21109</p>	<p>3. SIGNATURE OF EXAMINING PHYSICIAN <i>S. H. Williams M.D.</i> 19 Mar 82 (signature) (date)</p> <p>IMPORTANT: After signing, return the entire form intact in the pre-addressed "Confidential-Medical" envelope which the person you examined gave you.</p>	
<p>78-110</p>		
<p>STANDARD FORM NO. 78 OCTOBER 1969 (REVISION) CIVIL SERVICE COMMISSION FPM 339</p>		

Figure E-2. SF 78 (Certificate of Medical Examination)

NOTE TO EXAMINING PHYSICIAN: The person you are about to examine will have to cope with the functional requirements and environmental factors circled on the other side of this form. Please take them, and the brief description of job duties above them, into consideration as you make your examination and report your findings and conclusions.

1. HEIGHT: 6 FEET, — INCHES. WEIGHT: 183 POUNDS.

2. EYES:

(A) Distant vision (Snellen): without glasses: right 20 left 20; with glasses, if worn: right 20 left 20

(B) What is the longest and shortest distance at which the following specimen of Jaeger No. 2 type can be read by the applicant? Test each eye separately. See vision screener record.

Jaeger No. 2 Type _____ without glasses: _____ with glasses, if used: _____

R. _____ in. to _____ in. R. _____ in. to _____ in.

L. _____ in. to _____ in. L. _____ in. to _____ in.

(C) Color vision: Is color vision normal when Ishihara or other color plate test is used? YES NO
If not, can applicant pass lantern, yarn, or other comparable test? YES NO

3. EARS: (Consider denominators indicated here as normal. Record as numerators the greatest distance heard.)
Ordinary conversation: _____
Audiometer (if given):

250	500	1000	2000	3000	4000	5000	6000	7000	8000

RIGHT EAR _____ 20 ft. LEFT EAR _____ 20 ft.

4. OTHER FINDINGS: In items a through l briefly describe any abnormality (including diseases, scars, and disfigurements). Include brief history, if pertinent. If normal, so indicate.

a. Eyes, ears, nose, and throat (including teeth and oral hygiene): Normal

b. Head and back (including face, hair, and scalp): 5" surg. scar (L) past throat

c. Speech (note any malfunction): Normal

d. Skin and lymph nodes (including thyroid gland): Normal

e. Abdomen: Normal

f. Peripheral blood vessels: Normal

g. Excretory: Normal

h. Urinalysis (if indicated):
Sp. gr. _____ Sugar _____ Blood _____
Albumen _____ Casts _____ Pus _____

i. Respiratory tract (X-ray if indicated): Normal

j. Heart (size, rate, rhythm, function):
Blood pressure 150/90
Pulse 72
EKG (if indicated) WNL

k. Back (special consideration for positions involving heavy lifting and other strenuous duties): Normal

l. Neurological and mental health: Normal

CONCLUSIONS: Summarize below any medical findings which, in your opinion, would limit this person's performance of the job duties and/or would make him a hazard to himself or others. If none, so indicate.

No limiting conditions for this job
 Limiting conditions as follows:

REPORT OF MEDICAL HISTORY
(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY-CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

STANDARD FORM 93
JANUARY 1971
GSA FPMR 101-11.8

Approved
Office of Management and Budget No. 29-R0191

1. LAST NAME—FIRST NAME—MIDDLE NAME Doe, George A.		2. SOCIAL SECURITY OR IDENTIFICATION NO. 220-12-3231						
3. HOME ADDRESS (No. street or RFD, city or town, State, and ZIP CODE) 1006 Every Drive Edgewood, MD 21040		4. POSITION (Title, grade, component) Guard, GS-07						
5. PURPOSE OF EXAMINATION Annual physical	6. DATE OF EXAMINATION 18 March 1982	7. EXAMINING FACILITY OR EXAMINER, AND ADDRESS (Include ZIP Code) Occupational Health Clinic ABD Army Depot, XYZ, MD 21109						
8. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED (Follow by description of past history, if complaint exists) In good health.								
9. HAVE YOU EVER (Please check each item)		10. DO YOU (Please check each item)						
YES	NO	YES	NO					
(Check each item)								
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>					
Lived with anyone who had tuberculosis		Wear glasses or contact lenses						
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>					
Coughed up blood		Have vision in both eyes						
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>					
Bled excessively after injury or tooth extraction		Wear a hearing aid						
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>					
Attempted suicide		Stutter or stammer habitually						
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>					
Been a sleepwalker		Wear a brace or back support						
11. HAVE YOU EVER HAD OR HAVE YOU NOW (Please check at left of each item)								
YES	NO	DON'T KNOW	YES	NO	DON'T KNOW	YES	NO	DON'T KNOW
(Check each item)								
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Scarlet fever, erysipelas			Champs in your legs			"Trick" or locked knee		
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever			Frequent indigestion			Foot trouble		
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swollen or painful joints			Stomach, liver, or intestinal trouble			Neuritis		
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent or severe headaches			Gall bladder trouble or gallstones			Paralysis (include infantile)		
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness or fainting spells			Jaundice or hepatitis			Epilepsy or fits		
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye trouble			Adverse reaction to serum, drug, or medicine			Car, train, sea or air sickness		
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear, nose, or throat trouble			Broken bones			Frequent trouble sleeping		
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing loss			Tumor, growth, cyst, cancer			Depression or excessive worry		
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic or frequent colds			Rupture/hernia			Loss of memory or amnesia		
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Severe tooth or gum trouble			Piles or rectal disease			Nervous trouble of any sort		
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinusitis			Frequent or painful urination			Periods of unconsciousness		
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hay Fever			Bed wetting since age 12					
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Head injury			Kidney stone or blood in urine					
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin diseases			Sugar or albumin in urine					
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid trouble			VD—Syphilis, gonorrhea, etc.					
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis			Recent gain or loss of weight					
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma			Arthritis, rheumatism, or beritis					
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath			Bone, joint or other deformity					
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain or pressure in chest			Lameness					
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic cough			Loss of finger or toe			12. FEMALES ONLY: HAVE YOU EVER		
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Palpitation or pounding heart			Painful or "trick" shoulder or elbow			Been treated for a female disorder		
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart trouble			Recurrent back pain			Had a change in menstrual pattern		
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High or low blood pressure								
13. WHAT IS YOUR USUAL OCCUPATION? Security guard						14. ARE YOU (Check one) <input checked="" type="checkbox"/> Right handed <input type="checkbox"/> Left handed		

93-101-01

Figure E-3. SF 93 (Report of Medical History)

YES	NO	CHECK EACH ITEM YES OR NO. EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE ON RIGHT
<input checked="" type="checkbox"/>	<input type="checkbox"/>	15. Have you been refused employment or been unable to hold a job or stay in school because of: A. Sensitivity to chemicals, dust, sunlight, etc. B. Inability to perform certain motions. C. Inability to assume certain positions. D. Other medical reasons (If yes, give reasons.)
<input checked="" type="checkbox"/>	<input type="checkbox"/>	16. Have you ever been treated for a mental condition? (If yes, specify when, where, and give details.)
<input checked="" type="checkbox"/>	<input type="checkbox"/>	17. Have you ever been denied life insurance? (If yes, state reason and give details.)
<input checked="" type="checkbox"/>	<input type="checkbox"/>	18. Have you had, or have you been advised to have, any operations? (If yes, describe and give age at which occurred.)
<input checked="" type="checkbox"/>	<input type="checkbox"/>	19. Have you ever been a patient in any type of hospital? (If yes, specify when, where, why, and name of doctor and complete address of hospital.)
<input checked="" type="checkbox"/>	<input type="checkbox"/>	20. Have you ever had any illness or injury other than those already noted? (If yes, specify when, where, and give details.)
<input checked="" type="checkbox"/>	<input type="checkbox"/>	21. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (If yes, give complete address of doctor, hospital, clinic, and details.)
<input checked="" type="checkbox"/>	<input type="checkbox"/>	22. Have you ever been rejected for military service because of physical, mental, or other reasons? (If yes, give date and reason for rejection.)
<input checked="" type="checkbox"/>	<input type="checkbox"/>	23. Have you ever been discharged from military service because of physical, mental, or other reasons? (If yes, give date, reason, and type of discharge: whether honorable, other than honorable, for unfitness or unsuitability.)
<input checked="" type="checkbox"/>	<input type="checkbox"/>	24. Have you ever received, is there pending, or have you applied for pension or compensation for existing disability? (If yes, specify what kind, granted by whom, and what amount, when, why.)
		Had broken leg at age 12
		-----when broke leg
<p style="font-size: 2em; opacity: 0.5; transform: rotate(-15deg);">SAMPLE</p>		
<p>I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record for purposes of processing my application for this employment or service.</p>		
TYPED OR PRINTED NAME OF EXAMINER GEORGE A. DOE		SIGNATURE <i>George A. Doe</i>
NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL OFFICER ONLY." 25. Physician's summary and elaboration of all pertinent data (Physician shall comment on all positive answers in items 9 through 24. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.)		
TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER S. H. WILLIAMS, M.D.		DATE <i>18 Mar 82</i>
		SIGNATURE <i>S. H. Williams M.D.</i>
		NUMBER OF ATTACHED SHEETS 0

DEPARTMENT OF THE ARMY NONAPPROPRIATED FUNDS CERTIFICATE OF MEDICAL EXAMINATION		(Applicant must supply information below to heavy line) (Type or Print in Ink)	For use of this form, see AR 230-2; the proponent agency is The Adjutant General's Office.	
1. NAME (LAST—FIRST—MIDDLE) <i>Doe, Jane C.</i>		MR. <input checked="" type="checkbox"/> MRS.	2. SEX <input type="checkbox"/> MALE <input checked="" type="checkbox"/> FEMALE	3. BIRTH DATE (Mo., day, year) <i>Oct 2 1962</i>
4. SOCIAL SECURITY NO. <i>241-28-8308</i>		5. STREET ADDRESS AND APARTMENT NO. <i>5341 Harford Ave</i>		
6. CITY, STATE, AND ZIP CODE <i>Edgewater, MD 21004</i>		7. POSITION TITLE AND NUMBER <i>Child Care Attendant NAF 363</i>		8. PAY PLAN AND OCCUPATION CODE <i>Laborer NAF 15, 184</i>
9. GRADE OR LEVEL <i>P5 2/1</i>		10. SALARY <i>#3.54/h</i>		
11. NAME AND LOCATION OF EMPLOYING OFFICE <i>NAF Potomac Div Bldg 530, Rm 49 ABC Depot, MD 21111</i>				
12. (A) ARE YOU NOW EMPLOYED IN POSITION SHOWN IN ITEM 7 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		(B) IF "YES" GIVE THE DATE OF YOUR ORIGINAL APPOINTMENT TO THIS POSITION:		
13. (A) HAVE YOU ANY PHYSICAL DEFECT OR DISABILITY WHATSOEVER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF "YES," GIVE DETAILS.				
(B) DOES THE VETERANS ADMINISTRATION RECOGNIZE SERVICE-CONNECTED DISABILITY IN YOUR CASE? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
(C) HAVE YOU EVER RECEIVED DISABILITY RETIREMENT FROM THE U.S. CIVIL SERVICE COMMISSION OR A NONAPPROPRIATED FUND ACTIVITY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
Sign your name in INK as it appears on your application in the presence of the physician for purpose of identification			SIGNATURE OF APPLICANT <i>Jane C. Doe</i>	
DOCTOR: All questions on both sides of this certificate and on the lower half of the Health Qualification Placement Record must be answered. Before beginning the examination, refer to items 13 and 14 on the Health Qualification Placement Record, which you will have knowledge of the physical requirements of the position to which the applicant is appointed. Sign both this certificate and the Health Qualification Placement Record.				
1. HEIGHT: <i>5</i> FEET <i>7</i> INCHES		WEIGHT: <i>249</i> POUNDS		
2. EYES: (A) DISTANT VISION (Snellen): WITHOUT GLASSES: RIGHT <i>20</i> LEFT <i>20</i> WITH GLASSES, IF WORN: RIGHT <i>20</i> LEFT <i>20</i>				
(B) WHAT IS THE LONGEST AND SHORTEST DISTANCE AT WHICH THE FOLLOWING SPECIMEN OF JAEGER NO. 2 TYPE CAN BE READ BY THE APPLICANT? TEST EACH EYE SEPARATELY.				
WITHOUT GLASSES:		WITH GLASSES, IF USED:		
R. _____ IN. TO _____ IN.		R. _____ IN. TO _____ IN.		
L. _____ IN. TO _____ IN.		L. _____ IN. TO _____ IN.		
(C) EVIDENCE OF DISEASE OR INJURY: RIGHT _____ LEFT _____				
(D) COLOR VISION: IS COLOR VISION NORMAL WHEN ISHINARA OR OTHER COLOR PLATE TEST IS USED? <input type="checkbox"/> YES <input type="checkbox"/> NO				
IF NOT, CAN APPLICANT PASS LANTERN, YARN, OR OTHER COMPARABLE TEST? <input type="checkbox"/> YES <input type="checkbox"/> NO				
3. EARS: (CONSIDER DENOMINATORS INDICATED HERE AS NORMAL. RECORD AS NUMERATORS THE GREATEST DISTANCE HEARD)				
ORDINARY CONVERSATION:				
RIGHT EAR: <i>20 FT.</i>		LEFT EAR: <i>20 FT.</i>		
EVIDENCE OF DISEASE OR INJURY: RIGHT EAR _____ LEFT EAR _____				
4. NOSE	5. PARA NASAL SINUSES		6. MOUTH AND THROAT	
7. GASTRO-INTESTINAL				
(A) HISTORY OF PEPTIC ULCER: <input type="checkbox"/> YES <input type="checkbox"/> NO. IF "YES," IS ULCER: <input type="checkbox"/> ACTIVE <input type="checkbox"/> QUIESCENT				
<input type="checkbox"/> HEALED				
HOW LONG? _____ DATE OF LAST X-RAY _____				
SYMPTOMS PRESENT, IF ANY (Severity, frequency, etc.):				
TREATMENT (Use space under "Remarks," if needed):				
8. METABOLIC DISORDERS: (INDICATE ANY ABNORMALITY OF THE FOLLOWING GLANDS BY A CHECK IN THE APPROPRIATE BOX, AND EXPLAIN UNDER "REMARKS.")				
<input type="checkbox"/> THYROID <input type="checkbox"/> PANCREAS <input type="checkbox"/> PITUITARY <input type="checkbox"/> OVARIAN				

Figure E-4. DA Form 3437 (Certificate of Medical Examination (NAF))

HEALTH QUALIFICATION PLACEMENT RECORD (NONAPPROPRIATED FUNDS)

1. NAME (CAPS) LAST—FIRST—MIDDLE DOE JANE C		MR.—MISS—MRS.	2. SEX <input type="checkbox"/> MALE <input checked="" type="checkbox"/> FEMALE	3. BIRTH DATE (Mo., Day, Year) Oct 3 1962	4. SOCIAL SECURITY NO. 244-28-8305		
5. STREET ADDRESS AND APARTMENT NO. 5341 Roland AVE			6. CITY, STATE, AND ZIP CODE Eldersburg, MD 21001				
7. POSITION TITLE AND NUMBER Child Care Attendant NAF 363		8. PAY PLAN AND OCCUPATION CODE Instructional N 05, 189	9. GRADE OR LEVEL PS 2/1	10. SALARY \$3.57/14			
11. NAME AND LOCATION OF EMPLOYING OFFICE NAF Personnel Div Bldg 530 Rm 49 AFSC Depot, MD 2111							
12. (A) ARE YOU NOW EMPLOYED IN POSITION SHOWN IN ITEM 7 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			(B) IF "YES" GIVE THE DATE OF YOUR ORIGINAL APPOINTMENT TO THIS POSITION:				
TO BE COMPLETED BY APPOINTING OFFICER: SECTIONS 13 AND 14							
(A). BRIEF OUTLINE OF WHAT WORKER DOES For the physician's use, set down in brief and simple terms what the employer does on this job, including environmental details such as stairs to climb, distance to rest room facilities, cafeteria, work-shift, etc. (Use Section 13 below.)			(B). PHYSICAL DEMANDS OF THE POSITION In Section 14 below, encircle the number of those factors which are essential to the duties of the position for which this applicant is being considered. The blank space may be used for special factors not listed.				
13. TITLE OF POSITION AND OUTLINE OF WHAT WORKER DOES IN THIS POSITION / Address use of dictionary of occupational titles, as applicable							
<i>Evidence of physical suitability DA Form 3473 is required for positions involving direct physical contact with people, such as nursery positions, HR 230-2, para 2-8b.</i>							
TO BE COMPLETED BY EXAMINING PHYSICIAN: SECTIONS 14 THROUGH 20							
INSTRUCTIONS: The items circled below indicate the physical requirements of the position for which this individual is being considered. Indicate the individual's physical capacities for this position by placing an "X" in the appropriate column opposite the numbers encircled. If the individual has any other physical limitations relating to physical requirements not encircled or not covered by this form, indicate these under "Remarks" on the reverse side. Whenever PARTIAL capacity has been indicated, explain under "Remarks," giving specific quantities.							
14. PHYSICAL REQUIREMENTS			ENVIRONMENTAL FACTORS				
	CAPACITY				CAPACITY		
	FULL	PARTIAL	NONE		FULL	PARTIAL	NONE
1. OUTSIDE				18. WORKING AROUND MACHINERY WITH MOVING PARTS			
2. OUTSIDE AND INSIDE				19. MOVING OBJECTS OR VEHICLES			
3. EXCESSIVE HEAT				20. WORKING ON LADDERS OR SCAFFOLDING			
4. EXCESSIVE COLD				21. WORKING BELOW GROUND			
5. EXCESSIVE HUMIDITY				22. UNUSUAL FATIGUE FACTORS (Specify)			
6. EXCESSIVE DAMPNESS OR CHILLING				23. WORKING WITH HANDS IN WATER			
7. DRY ATMOSPHERIC CONDITIONS				24. EXPLOSIVES			
8. EXCESSIVE NOISE, INTERMITTENT				25. VIBRATION			
9. CONSTANT NOISE				26. WORKING CLOSELY WITH OTHERS	X		
10. DUST				27. WORKS ALONE			
11. SILICA, ASBESTOS, ETC.				28. PROTRACTED OR IRREGULAR HOURS OF WORK			
12. FUMES, SMOKE, OR GASES				29. SPECIAL FACTORS (Specify)			
13. SOLVENTS (Designating agent)							
14. GREASES AND OILS							
15. RADIANT ENERGY							
16. ELECTRICAL ENERGY							
17. SLIPPERY OR UNEVEN WALKING SURFACES							

14. PHYSICAL REQUIREMENTS (Continued)			FUNCTIONAL FACTORS				
	CAPACITY				CAPACITY		
	FULL	PARTIAL	NONE		FULL	PARTIAL	NONE
33. HEAVY LIFTING—45 POUNDS AND OVER				54. ABILITY FOR RAPID MENTAL AND MUSCULAR COORDINATION SIMULTANEOUSLY			
34. MODERATE LIFTING—15-44 POUNDS	X			55. ABILITY TO USE AND DESIRABILITY OF USING FIREARMS			
35. LIGHT LIFTING—UNDER 15 POUNDS				56. NEAR VISION CORRECTIBLE AT 13 TO 16 INCHES TO (Judge 1 to 4)			
36. HEAVY CARRYING—45 POUNDS AND OVER				57. FAR VISION CORRECTIBLE TO 20/20 TO 20/40			
37. MODERATE CARRYING—15-44 POUNDS				58. FAR VISION CORRECTIBLE TO 20/30 TO 20/100			
38. LIGHT CARRYING—UNDER 15 POUNDS				59. SPECIFIC VISUAL REQUIREMENT (Specify)			
39. STRAIGHT PULLING (HOURS)				60. BOTH EYES REQUIRED			
40. PULLING—HAND OVER HAND (HOURS)				61. DEPTH PERCEPTION			
41. PUSHING (HOURS)				62. ABILITY TO DISTINGUISH BASIC COLORS			
42. REACHING ABOVE SHOULDER				63. ABILITY TO DISTINGUISH SHADES OF COLORS			
43. USE OF FINGERS				64. HEARING (Aid permitted)			
44. BOTH HANDS REQUIRED				65. HEARING WITHOUT AID			
45. WALKING (HOURS)				66. SPECIFIC HEARING REQUIREMENTS (Specify)			
46. STANDING (HOURS)				67.			
47. CRAWLING (HOURS)				68.			
48. KNEELING (HOURS)				69.			
49. REPEATED BENDING (HOURS)				70.			
50. CLIMBING—LEGS ONLY (HOURS)							
51. CLIMBING—USE OF LEGS AND ARMS							
52. BOTH LEGS REQUIRED							
53. OPERATION OF CRANE, TRUCK, TUG, TRACTOR, OR MOTOR VEHICLE							
15. THIS PERSON SHOULD USE: (A) PROPERLY FITTED EYEGLASSES <input type="checkbox"/> (B) PROPERLY FITTED HEARING AID <input type="checkbox"/> (C) OTHER PROSTHETIC AID (Specify) <input type="checkbox"/>							
16. REMARKS AND RECOMMENDATIONS: <i>Qualification satisfactory</i> SAMPLE							
17. PHYSICAL HANDICAP CODE 00							
18. SIGNATURE OF PHYSICIAN OR EXAMINER <i>S. H. Williams, M.D.</i>				NAME TYPED OR PRINTED S. H. WILLIAMS, M.D.		DATE 14 Sep 81	
19. ADDRESS OF EXAMINING PHYSICIAN (Typed or printed) ABD Army Depot XYZ, Maryland 21109				20. DO YOU HAVE FEDERAL DESIGNATION? IF YES, SPECIFY. <input checked="" type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME <input type="checkbox"/> FEE BASIS			
TO BE COMPLETED BY SUPERVISOR							
21. POSITION TO WHICH INDIVIDUAL WAS ASSIGNED							
22. SIGNATURE OF SUPERVISOR				NAME TYPED OR PRINTED		DATE	

UNITED STATES CIVIL SERVICE COMMISSION

STATEMENT OF PHYSICAL ABILITY FOR LIGHT DUTY WORK

INSTRUCTIONS TO APPLICANT

Budget Bureau
Approved 50-RO392

Please read instructions for each section carefully before answering the questions. Type or print answers in ink. If additional details are required, use Section D. After completing this statement, be sure to sign your name and give the date in Section E. Your replies will be evaluated in terms of the particular position for which you are applying. (AT THE DISCRETION OF THE APPOINTING OFFICER, A MEDICAL EXAMINATION MAY BE REQUIRED.)

IDENTIFICATION OF APPLICANT

NAME (Last, First, Middle) Jones, Mary D.	DATE OF BIRTH (Mo., Day, Yr.) 12-16-46	SOCIAL SECURITY NUMBER 226 49 4600
ADDRESS (Number, Street, City, State and ZIP Code) 2100 Rosewood Edgewood, MD 21040	TITLE OF POSITION APPLIED FOR Typist	

SECTION A—PHYSICAL LIMITATIONS

Answer each circled item "YES" or "NO" by placing an "X" in the proper box below. If you answer "YES" to any circled item, give additional details in Section D.

	YES	NO
1. Do you have any problem:		
(a) reading small newspaper print (glasses permitted)?		
(b) reading ordinary newspaper headlines without glasses?		
(c) seeing distant objects with either eye (glasses permitted)?		
2. Do you have difficulty in distinguishing basic colors (red, green, blue)?		
3. Do you have difficulty in distinguishing shades of colors?		
4. Do you have any hearing problem, including hearing telephone conversations (hearing aid permitted)?		
5. Do you wear a hearing aid?		
6. Do you have any speech impairment which hinders:		
(a) person-to-person conversation?		
(b) telephone conversation?		
(c) talking to groups of people?		
7. Do you have an amputation or abnormality of a leg, foot, arm, hand, and/or finger?		
8. Do you have difficulty in using arms, hands, or fingers for reaching in any direction, grasping, handling, or fingering?		
9. Do you have any disease or disability which would make your employment in light duty work a hazard to yourself or others?		

SECTION B—PHYSICAL ENDURANCE FACTORS

Answer each circled item "YES" or "NO" by placing an "X" in the proper box to show your physical ability to carry out the listed activities during each work day. If you answer "NO" to any item, give additional details in Section D.

DURING THE WORK DAY ARE YOU PHYSICALLY ABLE TO PERFORM ACTIVITIES INVOLVING:

	YES	NO
1. Sitting for long periods of time?		
2. Standing for long periods of time?		
3. Some walking on flat surfaces, slight inclines, and occasionally climbing stairs?		
4. Frequent walking and/or climbing of stairs or steep inclines?		
5. Occasional pushing and pulling motions as needed? (For example, opening and closing doors, drawers, etc.)		
6. Frequent pushing and pulling motions? (For example, frequent opening and closing file drawers)		
7. Occasional bending, stooping, and crouching? (For example, reaching the bottom shelf of a supply cabinet)		
8. Frequent bending, stooping, and crouching? (For example, frequently opening and closing lower file drawers)		
9. Occasionally lifting objects weighing up to 10-12 lbs. and frequently carrying lightweight items? (For example, ledgers, dockets, or lightweight equipment)		
10. Occasionally lifting objects weighing up to 20-25 lbs. and frequently carrying objects weighing up to 10-12 lbs.?		

(CONTINUED ON REVERSE SIDE)

Standard Form 177
May 1968
U.S. Civil Service Commission
PM Chapter 339
177-101

Figure E-5. SF 177 (Statement of Physical Ability for Light Duty Work)

DEPARTMENT OF THE ARMY
NONAPPROPRIATED FUNDS

STATEMENT OF PHYSICAL ABILITY FOR LIGHT DUTY WORK
INSTRUCTIONS TO APPLICANT

Please read instructions for each section carefully before answering the questions. Type or print answers in ink. If additional details are required, use Section D. After completing this statement, be sure to sign your name and give the date in Section E. Your replies will be evaluated in terms of the particular position for which you are applying. (AT THE DISCRETION OF THE APPOINTING OFFICER, A MEDICAL EXAMINATION MAY BE REQUIRED.)

IDENTIFICATION OF APPLICANT

NAME (Last, First, Middle) Cobb, Mark Allen	DATE OF BIRTH (Mo., Day, Yr.) 11-16-40	SOCIAL SECURITY NUMBER 490 99 8332
ADDRESS (Number, Street, City, State and ZIP Code) 4004 Old Court Drive Baltimore, MD 21222	TITLE OF POSITION APPLIED FOR Clerk	

SECTION A—PHYSICAL LIMITATIONS

Answer each circled item "YES" or "NO" by placing an "X" in the proper box below. If you answer "YES" to any circled item, give additional details in Section D.

	YES	NO
1. Do you have any problem:		
(a) reading small newspaper print (glasses permitted)?	X	
(b) reading ordinary newspaper headlines without glasses?	X	
(c) seeing distant objects with either eye (glasses permitted)?	X	
2. Do you have difficulty in distinguishing basic colors (red, green, blue)?	X	
3. Do you have difficulty in distinguishing shades of colors?	X	
4. Do you have any hearing problem, including hearing telephone conversations (hearing aid permitted)?	X	
5. Do you wear a hearing aid?	X	
6. Do you have any speech impairment which hinders:		
(a) person-to-person conversation?	X	
(b) telephone conversation?	X	
7. Do you have an amputation or abnormality of a leg/foot, arm, hand, and/or finger?	X	
8. Do you have difficulty in using arms, hands, or fingers for reaching in any direction, grasping, handling, or fingering?	X	
9. Do you have any disease or disability which would make your employment in light duty work a hazard to yourself or others?	X	

SECTION B—PHYSICAL ENDURANCE FACTORS

Answer each circled item "YES" or "NO" by placing an "X" in the proper box to show your physical ability to carry out the listed activities during each work day. If you answer "NO" to any item, give additional details in Section D.

DURING THE WORK DAY ARE YOU PHYSICALLY ABLE TO PERFORM ACTIVITIES INVOLVING:

	YES	NO
1. Sitting for long periods of time?	X	
2. Standing for long periods of time?	X	
3. Some walking on flat surfaces, slight inclines, and occasionally climbing stairs?	X	
4. Frequent walking and/or climbing of stairs or steep inclines?	X	
5. Occasional pushing and pulling motions as needed? (For example, opening and closing doors, drawers, etc.)	X	
6. Frequent pushing and pulling motions? (For example, frequent opening and closing file drawers)	X	
7. Occasional bending, stooping, and crouching? (For example, reaching the bottom shelf of a supply cabinet)	X	
8. Frequent bending, stooping, and crouching? (For example, frequently opening and closing lower file drawers)	X	
9. Occasionally lifting objects weighing up to 10-12 lbs. and frequently carrying lightweight items? (For example, ledgers, dockets, or lightweight equipment)	X	
10. Occasionally lifting objects weighing up to 20-25 lbs. and frequently carrying objects weighing up to 10-12 lbs.?	X	

(CONTINUED ON REVERSE SIDE)

For use of this form, see AR 230-2; the proponent agency is The Adjutant General's Office.

DA FORM 3666
1 JAN 71

Figure E-6. DA Form 3666 (Statement of Physical Ability for Light Duty Work (NAF))

Standard Form 600
General Services Administration and
Interagency Committee on Medical Records
FPMR 101-11.806-8 Exception Approved by NARS
October 1976 1 Aug 79

HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE	
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)	
5 Mar 81	Agents Security Guard Exam	
18 Mar 81	No significant interval history	
	Qualified	
	<i>J. H. Williams, M.D.</i> S. H. WILLIAMS, M.D. 241-61-3731	
22 Jul 81	B.P. 150/110	
	Has been off since 6 Jul 81. Note from PMD says because of hypertension and contusion of left leg. Cleared for RTD.	
	<i>J. H. Williams, M.D.</i> S. H. WILLIAMS, M.D. 241-61-3731	
22 Jul 81	Recommend BP check. Employee will comply. Discussed importance of monitoring BP, diet and activities re hypertension. Employee interested and cooperative. BP 154/110.	
	<i>C. Mather, R.N.</i> C. MATHER, RN	
24 Jul 81	BP check - 148/108 @1410 hrs.	
	<i>C. Mather, R.N.</i> C. MATHER, RN	
<div style="font-size: 4em; opacity: 0.5; transform: rotate(-45deg); pointer-events: none;"> S A M P L E </div>		
PATIENT'S IDENTIFICATION (Use this Space for Mechanical Imprint)		
Wife: Margaret Address: 3302 Northern Road Baltimore, MD 21222 Home Phone: 786-3281 Post Ext: 2560 Supv Ext: 2660		PATIENT'S NAME (Last, First, Middle initial) DOE, GEORGE A.
YEAR OF BIRTH	RELATIONSHIP TO SPONSOR	COMPONENT / STATUS DEPART / SERVICE
28 Mar 24		
SPONSOR'S NAME		RANK / GRADE
SSAN OR IDENTIFICATION NO.		ORGANIZATION
220-12-3231		Civ Security
CHRONOLOGICAL RECORD OF MEDICAL CARE <small>Standard Form 600 600-108-01</small>		

Figure E-7. SF 600 (Chronological Record of Medical Care)

CARD BAUSCH & LOMB OCCUPATIONAL VISION TESTS
 WITH THE ORTHO-RATER

NAME John Doe NO. 000
 DEPT. ABC JOB Security Guard
 AGE 40 M F EXP. _____
 VISION: ALL-VIS. _____ D. FOCAL _____ FAR NEAR ONLY _____ HOC. COULAR _____ JOB SPECIAL _____ SAFETY _____
 DATE _____ TESTER _____ CLERK _____
 EXAM. IN LAST YEAR _____ CHANGE, IN YR _____
 NOTE: _____

BAUSCH & LOMB INCORPORATED
 ROCHESTER, N. Y.
 CATALOGUE NO. 71-21-62

PRINTED IN U.S.A.

		VISUAL PERFORMANCE PROFILE															
		P ₂ - 0 FAR															
PHORIA	VERTICAL	X	1	2	3	4	5	6	7	8	9						
	LATERAL	X	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
BOTH			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
ACUITY	RIGHT		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
	LEFT	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
DEPTH		0	1	2	3	4	5	6	7	8	9						
COLOR		0	1	2	3	4	5	6									
		P ₁ - 0 NEAR															
BOTH		0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
ACUITY	RIGHT	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
	LEFT	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
PHORIA	VERTICAL	X	1	2	3	4	5	6	7	8	9						
	LATERAL	X	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15

Figure E-8. Visual Performance Profile Card

RECORD OF OCCUPATIONAL EXPOSURE TO IONIZING RADIATION									
FOR INSTRUCTIONS, SEE REVERSE OF SHEET.									
1. IDENTIFICATION NUMBER		2. NAME (Last, first, middle initial)		3. SOCIAL SECURITY NUMBER		4. RANK/RATE, TITLE OF POSITION		5. DATE OF BIRTH (Day, month, year)	
NEL		Doe, George A.		220-12-3231		Security Guard		20 Mar 24	
PLACE WHERE EXPOSURE OCCURRED	PERIOD OF EXPOSURE		DOSE THIS PERIOD (rem)				ACCUMULATED DOSE (rem)		INITIAL
	FROM (Day-Mo-Yr)	TO (Day-Mo-Yr)	SKIN DOSE (Sift)	GAMMA AND X-RAY	NEUTRON	TOTAL THIS PERIOD	TOTAL LIFETIME	PERMISSIBLE LIFETIME (mR/yr)	
ACTIVITY	7	8	9	10	11	12	13	14	15
ABD Army Depot	14Nov80	11Dec80	00000	00000	00000	00000	00.622	140.00	BD
ABD Army Depot	12Dec80	8Jan81	00000	00000	00000	00000	00.622	140.00	BD
ABD Army Depot	9Jan81	13Feb81	00000	00000	00000	00000	00.622	140.00	BD
ABD Army Depot	14Feb81	12Mar81	00000	00000	00000	00000	00.622	140.00	BD
ABD Army Depot	13Mar81	12Apr81	00000	00000	00000	00000	00.622	140.00	BD
S A M P L E									
16. REMARKS (Continue on additional sheet if necessary)									
TO BE RETAINED PERMANENTLY IN INDIVIDUAL'S MEDICAL RECORD									

DD FORM 1141
1 MAY 67

PREVIOUS EDITIONS ARE OBSOLETE

Figure E-9. DD Form 1141 (Record of Occupational Exposure to Ionizing Radiation)

INDIVIDUAL SICK SLIP		DATE
<input checked="" type="checkbox"/> ILLNESS <input type="checkbox"/> INJURY		22 July 1981
LAST NAME - FIRST NAME - MIDDLE INITIAL OF PATIENT: Doe, George A.		ORGANIZATION AND STATION Security Guard
SERVICE NUMBER/SSN 3231	GRADE/RATE GS-07	
UNIT COMMANDER'S SECTION		MEDICAL OFFICER'S SECTION
IN LINE OF DUTY Nonoccupational		IN LINE OF DUTY Nonoccupational
REMARKS Return to duty clearance. Was on illness absence since 6 Jul 81.		DISPOSITION OF PATIENT <input checked="" type="checkbox"/> DUTY <input type="checkbox"/> QUARTERS <input type="checkbox"/> SICK BAY <input type="checkbox"/> HOSPITAL <input type="checkbox"/> NOT EXAMINED <input type="checkbox"/> OTHER (Specify):
		REMARKS Note from PMD - Qualified to return to duty.
SIGNATURE OF UNIT COMMANDER <i>C.D. Smith</i>		SIGNATURE OF MEDICAL OFFICER <i>D.W. Williams, M.D.</i>

DD FORM 689
1 MAR 82

PREVIOUS EDITIONS ARE OBSOLETE.

SAMPLE

Figure E-10. DD Form 689 (Individual Sick Slip)

15 June 1980

AK 40-66

REQUEST FOR PRIVATE MEDICAL INFORMATION		DATE
<i>For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General</i>		
PATIENT'S NAME AND SOCIAL SECURITY NUMBER	MEDICAL TREATMENT FACILITY (State and Location)	
REASON FOR REQUEST		
PRIVATE MEDICAL INFORMATION SOUGHT (Specify dates of hospitalization or clinic visits and diagnosis, if known)		
REQUESTOR'S NAME, TITLE, ORGANIZATION (AND SOCIAL SECURITY NUMBER)		
FOR USE OF MEDICAL TREATMENT FACILITY ONLY		
Check application: <input type="checkbox"/> APPROVED <input type="checkbox"/> DISAPPROVED (State reason for disapproval)		
SUMMARY OF PRIVATE MEDICAL INFORMATION RELEASED		
SIGNATURE OF APPROVING OFFICIAL	DATE	

DA FORM 4254-R, 1 Jul 74

(Paper size 8 x 10", Image size 7 x 9-4/10")

Figure 2-1. DA Form 4254-R.

Figure E-11. DA Form 4254-R (Request for Private Medical Information)

MEDICAL RECORD	AUTHORIZATION FOR DISCLOSURE OF INFORMATION <small>For use of this form, see AR 40-55; the proponent agency is Office of The Surgeon General</small>	
<p>This form will not be used for authorization to disclose alcohol or drug abuse patient information from medical records or for authorization to disclose information from records of an alcohol or drug abuse treatment program. For authorization to disclose alcohol or drug abuse patient information, see 42 CFR 2 and AR 600-85.</p> <p>(Pursuant to the Privacy Act of 1974, Public Law 93-579)</p>		
PHYSICIAN OR MEDICAL TREATMENT FACILITY AUTHORIZED TO RELEASE INFORMATION	It is understood that this authorization may be revoked at any time, if requested in writing, except to the extent that action will have already been taken.	
PATIENT DATA		
NAME (Last, First, MI)	DATE OF BIRTH	SOCIAL SECURITY/IDENTIFICATION NUMBER
PERIOD OF TREATMENT (Month, Day, Year)	TYPE OF TREATMENT <input type="checkbox"/> OUTPATIENT <input type="checkbox"/> INPATIENT <input type="checkbox"/> BOTH	
RESTRICTIONS ON INFORMATION (Specify)		
USE OF MEDICAL INFORMATION <input type="checkbox"/> FURTHER MEDICAL CARE <input type="checkbox"/> INSURANCE CLAIMS <input type="checkbox"/> ATTORNEY <input type="checkbox"/> DISABILITY DETERMINATION <input type="checkbox"/> OTHER (Specify)		
INFORMATION DESTINATION		
INDIVIDUAL OR ORGANIZATION TO WHOM INFORMATION SHOULD BE RELEASED (Name and Address)		
(ANY DISCLOSURE OF MEDICAL RECORD INFORMATION BY THE RECIPIENT(S) IS PROHIBITED EXCEPT WHEN IMPLICIT IN THE PURPOSES OF THIS DISCLOSURE)		
RELEASE AUTHORIZATION		
I hereby request and authorize the named physician/medical treatment facility to release the medical information described above to the named individual/organization indicated.	DATE	
SIGNATURE OF PATIENT/PARENT/GUARDIAN	RELATIONSHIP TO PATIENT	
IMPRINT OF PATIENT IDENTIFICATION PLATE WHEN AVAILABLE		

DA FORM XXXX-R

Figure E-12. DA Form XXXX-R (Authorization for Disclosure of Information)

THIS PAGE WAS LEFT BLANK INTENTIONALLY.

ARMY OCCUPATIONAL HEALTH REPORT		FOR INSTRUCTIONS SEE REVERSE		PERIOD COVERED		REPORTS CONTROL SYMBOL MED-20(RA)	
TO: HQDA (DASG-PSP) WASII DC 20310 FROM: ABD Army Depot XYZ, MD 21109		TO: HQDA (DASG-PSP) WASII DC 20310 FROM: ABD Army Depot XYZ, MD 21109		TO: HQDA (DASG-PSP) WASII DC 20310 FROM: ABD Army Depot XYZ, MD 21109		TO: HQDA (DASG-PSP) WASII DC 20310 FROM: ABD Army Depot XYZ, MD 21109	
THRU: HQ, USPAH, MEDDAC ATTN: AHDD-PVM FT DEF, MD 07809		THRU: COMMANDER US ARMY HEALTH SERVICES COMMAND ATTN: HSPA-P FORT SAM HOUSTON TX 70234		THRU: COMMANDER US ARMY HEALTH SERVICES COMMAND ATTN: HSPA-P FORT SAM HOUSTON TX 70234		THRU: COMMANDER US ARMY HEALTH SERVICES COMMAND ATTN: HSPA-P FORT SAM HOUSTON TX 70234	
AR 40-5. The regional office in the Office of the Surgeon General		AR 40-5. The regional office in the Office of the Surgeon General		AR 40-5. The regional office in the Office of the Surgeon General		AR 40-5. The regional office in the Office of the Surgeon General	
SECTION A - PERSONNEL DATA		SECTION B - INJURY AND ILLNESS		SECTION C - SELECTIVE HEALTH PROGRAMS		SECTION D - OCCUPATIONAL HEALTH SERVICES	
1. NAME	CIV 6870	1. ICD-9 CODE		1. PLACEMENT AUDITORS - NONJOB RELATED	1. 377	1. PERSONNEL WORKING WITH OCCUPATIONAL HEALTH HAZARDS	1. 377
2. GRADE	4421	2. ICD-9 CODE		2. PERIODIC SCREENING - NONJOB RELATED	77	2. PERSONNEL WORKING WITH CARCINOGENS	77
3. SERVICE	3341	3. ICD-9 CODE		3. PERIODIC VISION SCREENING - NONJOB RELATED	337	3. PERSONNEL RECEIVING PERIODIC EVALUATIONS	337
4. POSITION		4. ICD-9 CODE		4. PERIODIC HEARING SCREENING - NONJOB RELATED	1820	4. PERSONNEL WORKING IN NOISE HAZARDOUS AREAS	1820
5. BRANCH		5. ICD-9 CODE		5. PERIODIC SUPPLY EXAMINATIONS	2	5. PERSONNEL WORKING WITH CHEMICAL AGENTS	2
6. TITLE		6. ICD-9 CODE		6. PERIODIC DENTAL EXAMINATIONS	335	6. PERSONNEL WORKING WITH RADIATION	335
7. GRADE		7. ICD-9 CODE		7. PERIODIC TUBERCULOSIS EXAMINATIONS	2192	7. PERSONNEL WORKING WITH BIOLOGICAL AGENTS	2192
8. POSITION		8. ICD-9 CODE		8. PERIODIC TUBERCULOSIS EXAMINATIONS	401	8. PERSONNEL WORKING WITH OTHER HAZARDOUS AGENTS	401
9. TITLE		9. ICD-9 CODE		9. PERIODIC TUBERCULOSIS EXAMINATIONS	1637	9. PERSONNEL WORKING WITH OTHER HAZARDOUS AGENTS	1637
10. GRADE		10. ICD-9 CODE		10. PERIODIC TUBERCULOSIS EXAMINATIONS	42	10. PERSONNEL WORKING WITH OTHER HAZARDOUS AGENTS	42
11. POSITION		11. ICD-9 CODE		11. PERIODIC TUBERCULOSIS EXAMINATIONS	2203	11. PERSONNEL WORKING WITH OTHER HAZARDOUS AGENTS	2203
12. TITLE		12. ICD-9 CODE		12. PERIODIC TUBERCULOSIS EXAMINATIONS	667	12. PERSONNEL WORKING WITH OTHER HAZARDOUS AGENTS	667
13. GRADE		13. ICD-9 CODE		13. PERIODIC TUBERCULOSIS EXAMINATIONS	269	13. PERSONNEL WORKING WITH OTHER HAZARDOUS AGENTS	269
14. POSITION		14. ICD-9 CODE		14. PERIODIC TUBERCULOSIS EXAMINATIONS	71	14. PERSONNEL WORKING WITH OTHER HAZARDOUS AGENTS	71
15. TITLE		15. ICD-9 CODE		15. PERIODIC TUBERCULOSIS EXAMINATIONS	1	15. PERSONNEL WORKING WITH OTHER HAZARDOUS AGENTS	1
16. GRADE		16. ICD-9 CODE		16. PERIODIC TUBERCULOSIS EXAMINATIONS	1	16. PERSONNEL WORKING WITH OTHER HAZARDOUS AGENTS	1
17. POSITION		17. ICD-9 CODE		17. PERIODIC TUBERCULOSIS EXAMINATIONS	1	17. PERSONNEL WORKING WITH OTHER HAZARDOUS AGENTS	1
18. TITLE		18. ICD-9 CODE		18. PERIODIC TUBERCULOSIS EXAMINATIONS	1	18. PERSONNEL WORKING WITH OTHER HAZARDOUS AGENTS	1
19. GRADE		19. ICD-9 CODE		19. PERIODIC TUBERCULOSIS EXAMINATIONS	1	19. PERSONNEL WORKING WITH OTHER HAZARDOUS AGENTS	1
20. POSITION		20. ICD-9 CODE		20. PERIODIC TUBERCULOSIS EXAMINATIONS	1	20. PERSONNEL WORKING WITH OTHER HAZARDOUS AGENTS	1
21. TITLE		21. ICD-9 CODE		21. PERIODIC TUBERCULOSIS EXAMINATIONS	1	21. PERSONNEL WORKING WITH OTHER HAZARDOUS AGENTS	1
22. GRADE		22. ICD-9 CODE		22. PERIODIC TUBERCULOSIS EXAMINATIONS	1	22. PERSONNEL WORKING WITH OTHER HAZARDOUS AGENTS	1
23. POSITION		23. ICD-9 CODE		23. PERIODIC TUBERCULOSIS EXAMINATIONS	1	23. PERSONNEL WORKING WITH OTHER HAZARDOUS AGENTS	1
24. TITLE		24. ICD-9 CODE		24. PERIODIC TUBERCULOSIS EXAMINATIONS	1	24. PERSONNEL WORKING WITH OTHER HAZARDOUS AGENTS	1
25. GRADE		25. ICD-9 CODE		25. PERIODIC TUBERCULOSIS EXAMINATIONS	1	25. PERSONNEL WORKING WITH OTHER HAZARDOUS AGENTS	1
26. POSITION		26. ICD-9 CODE		26. PERIODIC TUBERCULOSIS EXAMINATIONS	1	26. PERSONNEL WORKING WITH OTHER HAZARDOUS AGENTS	1
27. TITLE		27. ICD-9 CODE		27. PERIODIC TUBERCULOSIS EXAMINATIONS	1	27. PERSONNEL WORKING WITH OTHER HAZARDOUS AGENTS	1
28. GRADE		28. ICD-9 CODE		28. PERIODIC TUBERCULOSIS EXAMINATIONS	1	28. PERSONNEL WORKING WITH OTHER HAZARDOUS AGENTS	1
29. POSITION		29. ICD-9 CODE		29. PERIODIC TUBERCULOSIS EXAMINATIONS	1	29. PERSONNEL WORKING WITH OTHER HAZARDOUS AGENTS	1
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31. GRADE		31. ICD-9 CODE		31. PERIODIC TUBERCULOSIS EXAMINATIONS	1	31. PERSONNEL WORKING WITH OTHER HAZARDOUS AGENTS	1
32. POSITION		32. ICD-9 CODE		32. PERIODIC TUBERCULOSIS EXAMINATIONS	1	32. PERSONNEL WORKING WITH OTHER HAZARDOUS AGENTS	1
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36. TITLE		36. ICD-9 CODE		36. PERIODIC TUBERCULOSIS EXAMINATIONS	1	36. PERSONNEL WORKING WITH OTHER HAZARDOUS AGENTS	1
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38. POSITION		38. ICD-9 CODE		38. PERIODIC TUBERCULOSIS EXAMINATIONS	1	38. PERSONNEL WORKING WITH OTHER HAZARDOUS AGENTS	1
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79. GRADE		79. ICD-9 CODE		79. PERIODIC TUBERCULOSIS EXAMINATIONS	1	79. PERSONNEL WORKING WITH OTHER HAZARDOUS AGENTS	1
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81. TITLE		81. ICD-9 CODE		81. PERIODIC TUBERCULOSIS EXAMINATIONS	1	81. PERSONNEL WORKING WITH OTHER HAZARDOUS AGENTS	1
82. GRADE		82. ICD-9 CODE		82. PERIODIC TUBERCULOSIS EXAMINATIONS	1	82. PERSONNEL WORKING WITH OTHER HAZARDOUS AGENTS	1
83. POSITION		83. ICD-9 CODE		83. PERIODIC TUBERCULOSIS EXAMINATIONS	1	83. PERSONNEL WORKING WITH OTHER HAZARDOUS AGENTS	1
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85. GRADE		85. ICD-9 CODE		85. PERIODIC TUBERCULOSIS EXAMINATIONS	1	85. PERSONNEL WORKING WITH OTHER HAZARDOUS AGENTS	1
86. POSITION		86. ICD-9 CODE		86. PERIODIC TUBERCULOSIS EXAMINATIONS	1	86. PERSONNEL WORKING WITH OTHER HAZARDOUS AGENTS	1
87. TITLE		87. ICD-9 CODE		87. PERIODIC TUBERCULOSIS EXAMINATIONS	1	87. PERSONNEL WORKING WITH OTHER HAZARDOUS AGENTS	1
88. GRADE		88. ICD-9 CODE		88. PERIODIC TUBERCULOSIS EXAMINATIONS	1	88. PERSONNEL WORKING WITH OTHER HAZARDOUS AGENTS	1
89. POSITION		89. ICD-9 CODE		89. PERIODIC TUBERCULOSIS EXAMINATIONS	1	89. PERSONNEL WORKING WITH OTHER HAZARDOUS AGENTS	1
90. TITLE		90. ICD-9 CODE		90. PERIODIC TUBERCULOSIS EXAMINATIONS	1	90. PERSONNEL WORKING WITH OTHER HAZARDOUS AGENTS	1
91. GRADE		91. ICD-9 CODE		91. PERIODIC TUBERCULOSIS EXAMINATIONS	1	91. PERSONNEL WORKING WITH OTHER HAZARDOUS AGENTS	1
92. POSITION		92. ICD-9 CODE		92. PERIODIC TUBERCULOSIS EXAMINATIONS	1	92. PERSONNEL WORKING WITH OTHER HAZARDOUS AGENTS	1
93. TITLE		93. ICD-9 CODE		93. PERIODIC TUBERCULOSIS EXAMINATIONS	1	93. PERSONNEL WORKING WITH OTHER HAZARDOUS AGENTS	1
94. GRADE		94. ICD-9 CODE		94. PERIODIC TUBERCULOSIS EXAMINATIONS	1	94. PERSONNEL WORKING WITH OTHER HAZARDOUS AGENTS	1
95. POSITION		95. ICD-9 CODE		95. PERIODIC TUBERCULOSIS EXAMINATIONS	1	95. PERSONNEL WORKING WITH OTHER HAZARDOUS AGENTS	1
96. TITLE		96. ICD-9 CODE		96. PERIODIC TUBERCULOSIS EXAMINATIONS	1	96. PERSONNEL WORKING WITH OTHER HAZARDOUS AGENTS	1
97. GRADE		97. ICD-9 CODE		97. PERIODIC TUBERCULOSIS EXAMINATIONS	1	97. PERSONNEL WORKING WITH OTHER HAZARDOUS AGENTS	1
98. POSITION		98. ICD-9 CODE		98. PERIODIC TUBERCULOSIS EXAMINATIONS	1	98. PERSONNEL WORKING WITH OTHER HAZARDOUS AGENTS	1
99. TITLE		99. ICD-9 CODE		99. PERIODIC TUBERCULOSIS EXAMINATIONS	1	99. PERSONNEL WORKING WITH OTHER HAZARDOUS AGENTS	1
100. GRADE		100. ICD-9 CODE		100. PERIODIC TUBERCULOSIS EXAMINATIONS	1	100. PERSONNEL WORKING WITH OTHER HAZARDOUS AGENTS	1

Figure E-13. DA Form 3076 (Army Occupational Health Report)

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MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA			
For use of this form, see AR 48-400; the proponent agency is the Office of The Surgeon General.			
REPORT TITLE Job Related Examination Questionnaire			OTSG APPROVED (Date) 15 February 1981
NAME (Last)	(First)	(Middle)	PHONE NO.: BUILDING NO.:
JOB TITLE:		NAME OF SUPERVISOR:	
A. NATURE OF HAZARD (Check any of these with which you now work):			
PHYSICAL:		CHEMICAL:	
1. <input type="checkbox"/> Heat		8. <input type="checkbox"/> Solvents	26. <input type="checkbox"/> Fiberglass
2. <input type="checkbox"/> Pressure		9. <input type="checkbox"/> Acids	27. <input type="checkbox"/> Herbicides
3. <input type="checkbox"/> High Places		10. <input type="checkbox"/> Resins, Polyesters	28. <input type="checkbox"/> Other
4. <input type="checkbox"/> Noise		11. <input type="checkbox"/> Fuels	
5. <input type="checkbox"/> Light		12. <input type="checkbox"/> Lubricants	
a. <input type="checkbox"/> Laser		13. <input type="checkbox"/> Paints	
b. <input type="checkbox"/> Arc or acetylene welding		14. <input type="checkbox"/> Alkalis	
6. <input type="checkbox"/> Radiation		15. <input type="checkbox"/> Electroplating	
a. <input type="checkbox"/> X-ray		16. <input type="checkbox"/> Chemical Cleaning	
b. <input type="checkbox"/> Isotopes (List on separate sheet)		17. <input type="checkbox"/> Chemical Milling	
c. <input type="checkbox"/> Ultraviolet		18. <input type="checkbox"/> Photography	
d. <input type="checkbox"/> RF (Microwave)		19. <input type="checkbox"/> Fumes (welding, heat treating, etc.)	
7. <input type="checkbox"/> Dust		20. <input type="checkbox"/> Refrigeration	
a. <input type="checkbox"/> Sandblasting		21. <input type="checkbox"/> Lead	
b. <input type="checkbox"/> Milling		22. <input type="checkbox"/> Mercury	
c. <input type="checkbox"/> Grinding		23. <input type="checkbox"/> Asbestos	
d. <input type="checkbox"/> Other		24. <input type="checkbox"/> Benzene	
		25. <input type="checkbox"/> Pesticides	
FREQUENCY OF EXPOSURE: ESTIMATE _____ HOURS/DAY/WEEK/MONTH			
ANY SYMPTOMS DUE TO EXPOSURE(S)?			
YES	NO		
<input type="checkbox"/>	<input type="checkbox"/>	1. <input type="checkbox"/> Headache	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	2. <input type="checkbox"/> Eye or nasal irritation	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	3. <input type="checkbox"/> Lung or bronchial tubes	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	4. <input type="checkbox"/> Skin rash or irritation	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	5. <input type="checkbox"/> Hands	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	6. <input type="checkbox"/> Face	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	7. <input type="checkbox"/> Chest	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	8. <input type="checkbox"/> Other	<input type="checkbox"/>
		9. <input type="checkbox"/> Nausea (sick stomach)	<input type="checkbox"/>
		10. <input type="checkbox"/> Dizziness	<input type="checkbox"/>
		11. <input type="checkbox"/> Loss of appetite	<input type="checkbox"/>
		12. <input type="checkbox"/> Metal fume fever	<input type="checkbox"/>
		13. <input type="checkbox"/> Never	<input type="checkbox"/>
		14. <input type="checkbox"/> Recently	<input type="checkbox"/>
		15. <input type="checkbox"/> Frequently	<input type="checkbox"/>
DO YOU HAVE ANY HEALTH PROBLEMS NOW? If yes, describe: <input type="checkbox"/> Yes <input type="checkbox"/> No			
PREPARED BY (Signature & Title)		DEPARTMENT/SERVICE/CLINIC	(Continue on reverse) DATE
PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)		<input type="checkbox"/> HISTORY/PHYSICAL	<input type="checkbox"/> FLOW CHART
		<input type="checkbox"/> OTHER EXAMINATION OR EVALUATION	<input type="checkbox"/> OTHER (Specify)
		<input type="checkbox"/> DIAGNOSTIC STUDIES	
		<input type="checkbox"/> TREATMENT	
DA FORM 4700 1 MAY 78		MEDDAC Form 280, 22 Feb 81	

Figure E-14. DA Form 4700 (Medical Record Supplemental Medical Data)

B. PREVIOUS WORK HISTORY:
Have you ever been exposed to any of the above physical or chemical hazards? Yes No
If answer is "Yes", list by number and explain those hazards to which you have been exposed.

C. DO YOU NOW OPERATE HEAVY EQUIPMENT (Forklift, crane, vehicles above 4 ton, etc.)? Yes No

EXAMINER'S COMMENTS

SAMPLE

PRIVACY ACT STATEMENT - HEALTH CARE RECORDS		
<p>THIS FORM IS NOT A CONSENT FORM TO RELEASE OR USE HEALTH CARE INFORMATION PERTAINING TO YOU:</p>		
<p>1. AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER (SSN)</p> <p>Sections 133, 1071-87, 3012, 5031 and 8012, title 10, United States Code and Executive Order 9397.</p>		
<p>2. PRINCIPAL PURPOSES FOR WHICH INFORMATION IS INTENDED TO BE USED</p> <p>This form provides you the advice required by The Privacy Act of 1974. The personal information will facilitate and document your health care. The Social Security Number (SSN) of member or sponsor is required to identify and retrieve health care records.</p>		
<p>3. ROUTINE USES</p> <p>The primary use of this information is to provide, plan and coordinate health care. As prior to enactment of the Privacy Act, other possible uses are to: Aid in preventive health and communicable disease control programs and report medical conditions required by law to federal, state and local agencies; compile statistical data; conduct research; teach; determine suitability of persons for service or assignments; adjust care claims and determine benefits; other lawful purposes, including law enforcement and litigation; conduct authorized investigations; evaluate care rendered; determine professional certification and hospital accreditation; provide physical qualifications of patients to agencies of federal, state, or local government upon request in the pursuit of their official duties.</p>		
<p>4. WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY AND EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION</p> <p>In the case of military personnel, the requested information is mandatory because of the need to document all active duty medical incidents in view of future rights and benefits. In the case of all other personnel/beneficiaries, the requested information is voluntary. If the requested information is not furnished, comprehensive health care may not be possible, but CARE WILL NOT BE DENIED.</p> <p>This all inclusive Privacy Act Statement will apply to all requests for personal information made by health care treatment personnel or for medical/dental treatment purposes and will become a permanent part of your health care record.</p> <p>Your signature merely acknowledges that you have been advised of the foregoing. If requested, a copy of this form will be furnished to you.</p>		
SIGNATURE OF PATIENT OR SPONSOR	SSN OF MEMBER OR SPONSOR	DATE
<i>Samuel E. Jacks</i>	789-24 7889	15 Mar 81
<p>DD FORM 2005 1 FEB 76 PREVIOUS EDITION IS OBSOLETE.</p>		

Figure E-15. DD Form 2005 (Privacy Act Statement - Health Care Records)

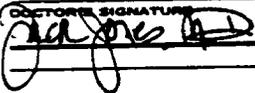
Standard Form 513 Rev. August 1974 Bureau of the Budget Circular A-32		U.S. GOVERNMENT PRINTING OFFICE 1967 O-300437	
CLINICAL RECORD		CONSULTATION SHEET	
REQUEST			
TO: Eye Clinic		FROM: (Reporting ward, unit, or center) Occupational Health Service	DATE OF REQUEST 10/10/81
REASON FOR REQUEST (Complaints and findings) Request evaluation of ocular motility, media and fundus, corrected visual acuity for near and far vision and slit lamp exam of the lens with the pupils widely dilated.			
PROVISIONAL DIAGNOSIS Laser contact			
DOCTOR'S SIGNATURE 	APPROVED	PLACE OF CONSULTATION <input type="checkbox"/> RESIDENCE <input checked="" type="checkbox"/> ON CALL	<input type="checkbox"/> EMERGENCY <input checked="" type="checkbox"/> ROUTINE
CONSULTATION REPORT			
SAMPLE			
(Continued on reverse side)			
SIGNATURE AND TITLE	DATE	IDENTIFICATION NO.	ORGANIZATION
PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)		REGISTER NO.	WARD NO.
NAME: John Doe	SSN: 000-00-0000	CIV EMP	Occupational Health Service
			CONSULTATION SHEET Standard Form 513 513-104

Figure E-16. SF 513 (Consultation Sheet)

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OSHA NO. 100F
JAN. 1, 1976

RECORDABLE CASES: You are required to record information about every occupational death; every nonfatal occupational illness; and those nonfatal occupational injuries which involve one or more of the following: loss of workdays, loss of consciousness, restriction of work or motion, transfer to another job, or medical treatment (other than first aid).
More complete definitions appear on the other side of this form.

LOG OF FEDERAL OCCUPATIONAL INJURIES AND ILLNESSES

This is the separate log for Civilian Personnel Military (Non-combat Personnel)

CASE OR FILE NUMBER	DATE OF INJURY OR ONSET OF ILLNESS	EMPLOYEE'S NAME (First name or initial, middle initial, last name)	OCCUPATION (Enter regular job title, not activity employee was performing when injured or onset of illness.)	DEPARTMENT (Enter department in which the employee is regularly employed.)	DESCRIPTION OF INJURY OR ILLNESS (Nature of injury or illness and Part(s) of Body Affected (Typical entries for this column might be: Application of first-aid to right forearm; Contact dermatitis on both hands; Electroshock to body.)	INJURY OR ILLNESS CODE (See codes on bottom of page.)	EXTENT OF AND OUTCOME OF CASES			NONFATAL CASES WITHOUT LOSST WORKDAYS (Enter a check if no workdays were lost. Enter number of days of RESTRICTED WORK ACTIVITY due to injury or illness.)	TERMINATIONS OR PERMANENT TRANSFERS (Enter a check if the entry in column 6 above is terminated or a permanent transfer.)
							DEATHS (Enter date of death.)	LOST WORKDAYS (Enter number of days of RESTRICTED WORK ACTIVITY due to injury or illness.)	LOST WORKDAYS (Enter a check if case involved lost workdays.)		
81-1	02/04/81	Arnar K. Hasiback	editors assistant	Gen Admin. and Information Systems	Spinal-cord acc. Confusion, slurred speech, loss of consciousness	10					
81-2	04/24/81	Michael Peltt	engineer	Gen Admin. Div.	Slipped on floor, head	10					
81-3	07/11/81	Deana Crane	Data Transcriber	Gen Admin. Div.	Slipped on floor, head	10					
81-4	11/14/81	Cecil F. Stokes	Administrative Assistant	Gen Admin. Div.	Slipped on floor, head	10					

SAMPLE

Injury Code

10 All occupational injuries

Sickness Code

21 Occupational skin diseases or disorders

22 Dust diseases of the lungs (pneumoconiosis)

23 Respiratory conditions due to toxic agents

24 Poisoning (systemic effects of toxic materials)

25 Disorders due to physical agents (other than basic materials)

26 Disorders due to repeated trauma

27 All other occupational illnesses

Figure E-20. OSHA No. 100F (Log of Federal Occupational Injuries and Illnesses)

APPENDIX F

GUIDELINES FOR WRITING OBJECTIVES*

Under normal circumstances, a well-formulated objective meets the following:

1. Starts with an action verb.
2. Specifies a single key result to be accomplished.
3. Specifies a target date for its accomplishment.
4. Is as specific and quantitative (and hence measurable and verifiable) as possible.
5. Specifies only the "what" and "when"; it avoids venturing into the "why" and "how."
6. Relates directly to the accountable manager's roles and mission and to higher-level roles, missions, and objectives.
7. Is readily understandable by those who will be contributing to its attainment.
8. Is realistic and attainable, but still represents a significant challenge.
9. Provides maximum payoff on the required investment in time and resources as compared with other objectives being considered.
10. Is consistent with the resources available or anticipated.
11. Is consistent with basic DA regulations and organizational policies and practices.

* SOURCE: George L. Morrissey, Management by Objectives and Results, Addison-Wesley, Reading, MA, 1970.

APPENDIX G

OPERATING PROGRAM DOCUMENT

The following sample statements might be used in a local OHS operating program document. It is not inclusive but representative of the possible content for each phase of the document. The format and degree of detailed content in the local document will depend on local guidance.

MISSION

The Occupational Health Service is a medical treatment facility, administratively under DPCCM with program technical guidance from PMA, that provides and/or coordinates a health care program to promote and maintain the physical and mental fitness of military and civilian employees.

MISSION PROGRAMS AND OBJECTIVES

1. Inventory of occupational health hazard (LOHHI).
 - a. Provide a comprehensive, current listing of all chemical, physical, biological, and psychological hazards to which civilian and military employees are potentially exposed at _____. For each work location and operation, LOHHI will specify the hazards present, protective equipment or controls used, and the number of military and civilian personnel potentially exposed.
 - b. Provide definitive exposure data for all (100%) operations having potential exposure to known or suspected carcinogens.
 - c. Provide the medical review of the hazard inventory at least annually and whenever changes occur.
 - d. Obtain a listing of all military and civilian personnel with potential health hazards requiring medical monitoring starting with those working with known or suspected carcinogens.
 - e. Etc.
 - f. Etc.
2. Job-Related Medical Surveillance.
 - a. Complete all preplacement examinations and provide the CPO with the Health Qualification Statement NLT _____ working days after the examination is requested.
 - b. Provide 90 percent of all new employees, who were not required to have preplacement examinations, with a health history, an audiogram, vision screening, and a blood pressure test within _____ month(s) after hire.
 - c. Provide the required hazard specific medical monitoring examinations, IAW DASG medical surveillance guidance, each quarter for 25 percent of all civilian and military personnel potentially exposed to occupational health hazards.

- d. Provide medical surveillance IAW OPM standares, each quarter for 25 percent of all persons in positions requiring physical fitness.
 - e. Etc.
 - f. Etc.
3. Pregnancy Surveillance.
- a. Identify 95 percent of all military and civilian women employees who become pregnant within their first trimester.
 - b. Identify all work areas where there are hazards that are potentially harmful to the presnant woman or the fetus.
 - c. Etc
4. Etc.
5. Etc.

POLICIES

1. The OHS staff will use the health hazard inventory as the basis for the medical surveillance program. Medical review of the LOHHI wtil emphasize identification of critical health hazards.
2. To avoid duplication of effort and resources, the MTF laboratory, x-ray and related resources will continue to be used to supplement the OHS job-related medical surveillance and patient treatment services. The MTF activities will be kept informed dS to projected requirements to facilitate allocation of their resources.
3. Job-related medical monitoring will be specific to the hazard or physical requirements of the job with priority given to workers in high risk areas.
4. Emphasis will be given to identifying the priority (high risk) areds requiring job-related health education and coordinating with all personnel concerned (supervisors, safety, etc.) to provide this employee education.
5. Technical competence of the OHS staff will be maintained by inservice education including programs offered by MEDDAC; encouragement of staff to keep up with professional journals and participate in local professional organization activities; and attendance at professional conferences or courses.
6. Etc.

TRENDS

1. Occupational health hazards have been listed for approximately 80 percent of all work locations. Of these only about one half of those with potential carcinogenic exposures have been evaluated to define the extent of exposure. Compliance with legal and regulatory requirements necessitates assigning high priority to completing the inventory and to determine all actual carcinogenic exposures.
2. The expanded hazard inventory and related increased identification of personnel with potential exposures (including military) with increase the demands for job-related medical surveillance. Accomplishment of this with current resources mandates that medical surveillance will be specific to the hazard or job requirements. No elective health evaluations can be offered.
3. The increasing emphasis by OSHA and DOD on job-related health education for employees requires a better organized and coordinated approach to providing the service. Policies need to be reviewed or developed to define objectives, scope, responsibilities, and other aspects of the program.
4. Evidence of misuse of authorized first aid kits in work areas will require a more careful monitoring of their use, and removal of the kits if indicated.
5. Etc.
6. Etc.

APPENDIX H

EPIDEMIOLOGY AS A TOOL IN OCCUPATIONAL HEALTH

H-1. Epidemiology is "the study of environmental, personal, and other factors that determine the incidence of disease."* In occupational health epidemiologic investigation of the incidence of occupational illness or injury is used to detect previously unrecognized hazards, uncontrolled hazards, or unusual susceptibility of individuals to hazards. This information, in turn, provides the basis for determining and establishing methods to prevent or control the incidence of occupational illness or injury.

H-2. Basic epidemiology requires the medical practitioner to be alert to the health status of the entire worker population. The fundamentals of good epidemiology begin with astute observation of changes in worker environment or health status and careful description and documentation of these observations. It requires a constant awareness that an individual with an occupationally-related illness or injury or with abnormal findings on a job-related examination may be the first indication of a possible epidemic.

H-3. Some general guidelines for initial investigation of the cause or causes of an occupationally-related illness or injury are listed below and/or shown in the following flow diagram (fig H-1).

a. Take a thorough medical history from affected individual(s);

- (1) A careful description of all signs and symptoms,
- (2) Date and time of onset and duration of signs and symptoms,
- (3) Location, and activity at time of onset (if an acute illness),
- (4) Recent medical history including medications, treatments, smoking history, etc.

b. Take a thorough occupational history. If the illness is acute, emphasis should be on a complete description of the individual's current work activity;

- (1) Specific work area (building number, room, and worksite),

* Schilling, R. S. F. (Ed.), Occupational Health Practice, Butterworth and Co., Ltd., Toronto, Canada, 1973, p. 169.

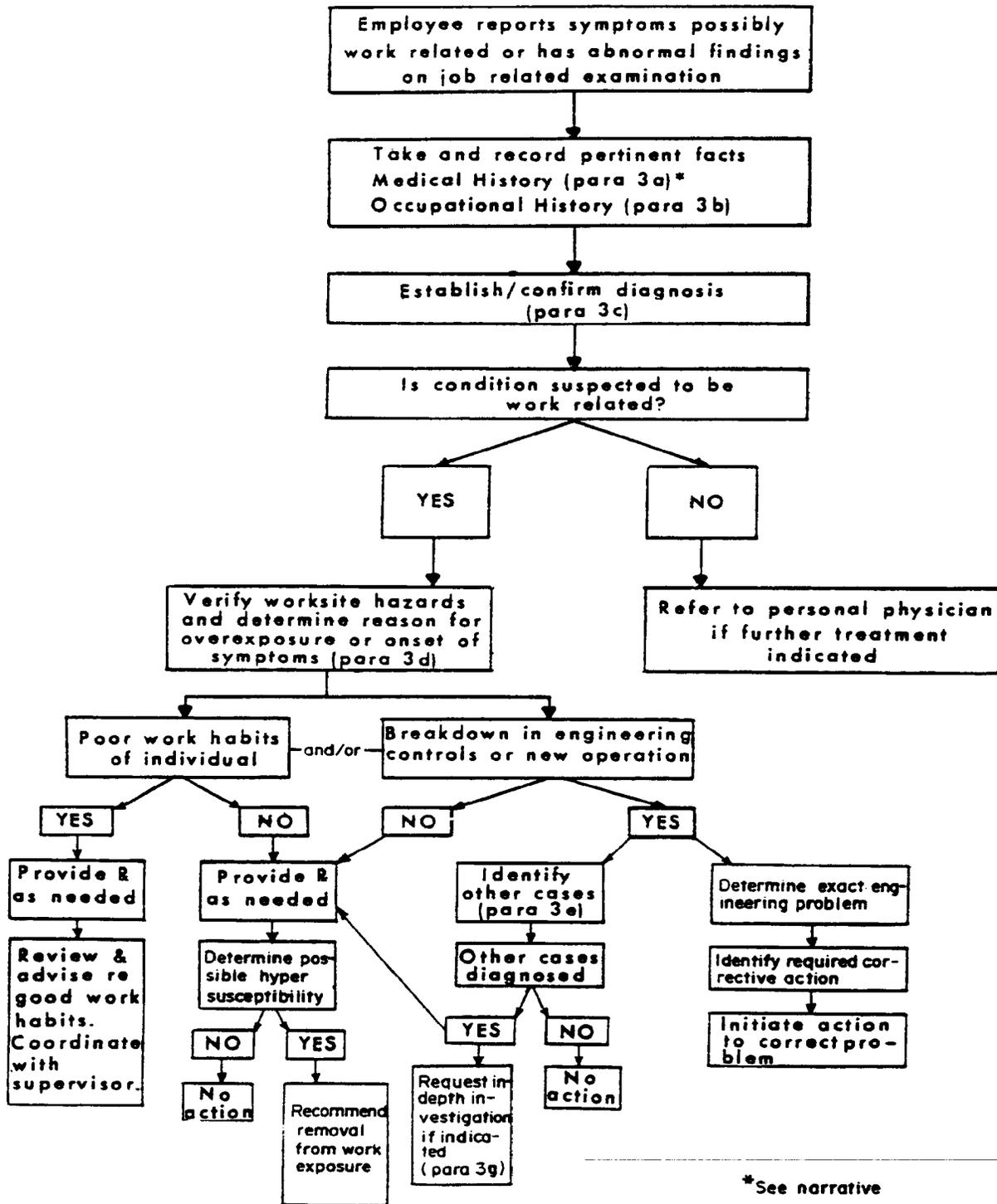


Figure H-1. Epidemiology flow diagram

- (2) A complete list of all possible exposures known to employee,
- (3) Exact nature of the work performed,
- (4) Amount of time actually spent performing task/working with suspected hazard,
- (5) Personal work habits,
- (6) Personal protective equipment used,
- (7) Areas where coffee and lunch breaks are taken.

Attention should also be given to previous work history, attempting to identify past exposures, including nonwork exposures such as hobbies or home work projects, which may predispose to or contribute to the present illness or injury. If the illness is chronic in nature, past occupational history and exposures become more important. Previous exposures should be identified and characterized in terms of duration of exposure; potential for high, medium, or low level exposures; and frequency of exposure.

c. Establish or confirm the diagnosis. Provide the patient with the appropriate medical examination. Document physical examination findings with appropriate laboratory and clinical studies. Keep accurate and well organized records of results.

d. Verify worksite hazards. Review LOHHI records. Coordinate with industrial hygiene and safety, talk to supervisors, and make a worksite visit to try to determine what the causative agent may be. Note any new operations or changes in old operations and try to determine associations between patient contact and onset of signs or symptoms. Obtain workplace environmental sampling data from industrial hygiene personnel. Request additional samples be taken or a survey be conducted, if indicated.

e. Identify other cases. What is the total population at risk to the same illness or injury? How many work in the same building, same room or work area, and/or on the same type of job as the ill or injured person? How many work with the same chemical or other potential hazard? Determine if any other people are experiencing the same signs or symptoms or if other workers have had abnormal medical examination findings or have been diagnosed to have the same illness or injury. This may be accomplished through a medical records review and/or interviews with workers. Go through items a through d above, with those individuals who do have questionable symptoms or examination findings.

f. Organize all the collected data. Use tables, charts, graphs, and drawings of the physical plant as indicated to make the information as clear as possible. Look for common items which are associated with the symptomatic workers.

g. If the cause is not readily apparent, or if more detailed investigation is indicated, request assistance - through channels - from the MEDCEN and/or USAEHA. The information gathered thus far will be a very good starting point for conducting a more complete epidemiologic investigation.

h. When the cause is determined, take appropriate action to correct the problem and protect workers.

APPENDIX I

HEALTH AND WORK HISTORY

I-1. The health and work history is an essential part of any physical examination. It provides a comprehensive account of the individual's past and present health and illness experience and of occupational and personal activities that may have an effect on his health. It serves as one of the bases for determining the scope of the examination, as well as other health care actions. In addition, a carefully conducted history can assist in establishing or strengthening an effective working relationship with employees.

I-2. Various guides are available on the process of history taking (sec II, app A). Some of the major factors to keep in mind include:

a. Conduct the interview where there is a reasonable amount of privacy and freedom from interruption

b. Establish and maintain (demonstrate) an attitude of interest and respect for the individual

c. Avoid monotonous recitation or reading of routine questions.

d. Followup on brief responses to get full details of pertinent items in the history, such as the what, when, extent, and results of surgery or the when, what kind, and how much of a toxic agent was worked with.

e. Allow the individual time to consider and respond to history inquiries, being sure he understands what is being asked and why and that you understand his responses.

f. Observe and record pertinent data about the individual's general appearance, personal hygiene, signs of nervousness or nervous mannerisms, attitude, physical defects, and how he responds to questions and instructions.

I-3. Use of printed history forms (SF 93) that the employee fills out saves time and allows the employee time to complete the form at his own pace. Then the employee does fill out his own history form, the nurse should review it carefully with him to clarify any questions and to obtain any additional information required. When a preprinted history form is not used, it is useful to have a check list of the data elements required. This will facilitate the conduct of the interview as well as help assure that all essential data are collected.

it-4. The initial health history, usually conducted at the time of the preplacement or new hire health evaluation, will be more comprehensive than subsequent histories conducted with periodic or other examinations. Standard Form 93 is used to record this baseline medical history. Additional data normally required (e.g., smoking, alcohol, drug usage; prescribed medications; past work history and exposures, etc.) may be entered on SF 93. If such data are extensive, SF 507 (Report on _____ or Continuation of SF _____) should be used as the continuation sheet for recording the information. When used, the SF 507 should be referenced on the SF 93,

it-5. Although SF 93 may be used for the health and work history taken with periodic examinations, it may be more practical to record such interim information on SF 600. In this case, interim history data checklists specific to the most common hazards or job requirements are particularly useful. For example, individuals working with compounds known to affect the pulmonary system should be asked about such symptoms as shortness of breath, cyanosis, numbness, lethargy, cough/sputum, chest pain, etc.

it-6. Health and work history data that usually are needed, supplementary to the SF 93 data, include:

a. Family history. Cardiovascular/cardiopulmonary disease, diabetes, cancer.

b. Social history. Tobacco, alcohol, other drugs; hobbies, recreational activities.

c. Medical history. Current or recent health problems and/or pertinent details about significant and/or chronic conditions checked on SF 93; medications; allergies; name of private physician. Employees working with potential health hazards should be asked about the occurrence of symptoms specific to the hazard, such as rashes or breathing problems when working with certain chemicals. For employees with potential exposure to communicable diseases emphasis should be given to their history of childhood diseases, such as rubella, chicken pox, mumps, pertussis, etc., including immunization status.

d. Work history. For job applicants, identify the kind of previous work done (including military), types of health hazards, and how long the individual worked at each job. For newly employed personnel receiving a baseline health evaluation after hire, identify previous types of work and work hazards, including length of exposures. For current employees, verify kind of work done since last examination to include types and extent of potential health hazard exposures and protective equipment used. Review of job exposures should also consider other work being done, such as home projects or crafts or other jobs/moonlighting.

APPENDIX J

FIRST-AID KITS

J-1. The placement of first-aid kits in work areas of installations is, in general, discouraged. Treatment from first-aid kits may result in inadequate therapy, nonreporting of occupational illness and injury, and loss of epidemiological data essential to prevention and control of occupational illness and injury.

J-2. There are two situations in which first-aid kits may be necessary.

a. When potential exposure to a highly toxic, fast acting chemical exists, first-aid kits containing specific treatments or antidotes should be readily available in the work area. [Example of this type of chemical are nerve gases, hydrogen cyanide (HCN)]. All personnel assigned to the area should be trained and be proficient in the use of the kit and in appropriate life saving procedures. Regular, periodic practice sessions should be held for all personnel in order to maintain first-aid skills.

b. At some large installations, it may be feasible to place first-aid kits in remote areas. The need for, as well as the selection of, equipment and supplies should be determined by the medical officer in charge after an evaluation of the specific work area. The types of hazards involved, the distance from definitive medical care, available transportation, and the level of training of individuals providing first aid should all be considered.

J-3. In all areas where first-aid kits are deemed necessary by local medical personnel, one individual on each work shift (and at least one alternate) who has current certification from an approved first-aid training course should be assigned to provide all first-aid treatment. In addition, these individuals should be responsible for the proper recording and reporting of illnesses and injuries as well as maintaining the contents of the kit. A trained first-aider on each shift is a requirement of OSHA (29 CFR 1910.151). Occupational illnesses and injuries must be reported in accordance with AR 40-5, AR 385-10, AR 385-40, and FPM Chapter 810, and PL 91-596 for the protection of the employee and the employer.

J-4. Only persons with current training in first-aid procedures should provide first-aid treatment. Approved first-aid training may be obtained through satisfactorily completing the first-aid course offered by the American National Red Cross. Additionally, in certain circumstances, selected personnel should become certified emergency medical technicians if the course is available. All workers should be encouraged to take instruction in cardio-pulmonary resuscitation.

APPENDIX K
EXAMPLE OF OCCUPATIONAL HEALTH EDUCATION PLAN

The following chart outlines the projected health education activities of the OHS for a 3-month period.

<u>Month</u>	<u>Need</u>	<u>Objective</u>	<u>Health Education Action</u>	<u>Followup</u>
January	Poor compliance with requirement to use respiratory protective equipment. Workers complain of poor fit of equipment, lack of parts, etc.	95-100 percent compliance with respiratory protection program.	Instruction (group and one-to-one) on how to fit and care for respirators. Discuss and provide written back up data on hazards of potential work exposures requiring use of respirators. Coordinate with supervisors to assure availability of replacement parts.	Observe compliance during visits to work areas. Determine, with supervisors and workers, reasons for noncompliance and reinforce previous instructions.
February	Community Heart Month. Average age of workers 44 years. Several incidences of heart attacks in past year among workers.	Increased understanding of causes of heart disease by workers and improved personal health habits (weight and smoking control, exercise). Identify workers with high blood pressure (over 160) and refer to personal physician for care.	Article on prevention of heart disease in post publication. Pamphlets on heart disease, obesity, smoking in OHS waiting room. List of resources to assist individuals in weight and smoking control posted in OHS. Conduct a hypertension screening program.	Maintain record of employee inquiries about prevention of CVD and requests for information on weight control, etc. Followup all personnel referred to their physicians for hypertension to identify those under care, etc.
March	Increased incidence of dermatitis and other complaints of personnel working with solvents, apparently due to poor work habits and limited knowledge of potential health hazards of solvents.	Cut current incidence of solvent related health problems by 95 percent.	Coordinate with supervisor and safety work practices, including use of protective equipment and worker controls. Review/reinforce instructions on proper practices, including personal hygiene. Discuss with supervisor and employees solvent hazards and how they affect health of employee. Explain health aspects of hazard data sheets.	Maintain record of incidence of new or recurring solvent related health problems. Observe compliance with proper procedures during worksite visits. Note questions of supervisors and employees indicating need for further explanation about hazards, etc.

APPENDIX L

NEW EMPLOYEE FACT SHEET

The following provides a suggested outline for an orientation fact sheet or pamphlet to provide employees with a description of the OH Program and guidance for using its services.

OCCUPATIONAL HEALTH SERVICE

1. Purpose of the Occupational Health Program:
2. Eligibility: *State who is eligible for OH services, e.g., civilian and military employees. This may include a definition of who is eligible for full services and who is eligible for limited services, e.g., contractor employees.*
3. Location and Hours: *Specify hours and where to obtain care on each shift, including weekends and holidays.*
4. Occupational Health Service Phone Number:
5. Programs Provided: *Identify all OHP provided (see examples below).*

Examples:

Replacement, periodic and termination job-related physical examinations
Fitness for duty and other administrative physical examinations
Treatment of injury and illness
Job-related and general health education and counseling
Pregnancy evaluation in relation to job assignment
Chronic disease surveillance
Sickness absence monitoring
Immunizations
Worksite visits and evaluations, etc.

6. Occupational Injury Forms Required: (CA-16, etc.)
7. Health Records: *Specify provisions of the privacy act. If indicated, identify content such as inclusion of medical data pertinent to work assignments, where records are kept, procedures in handling records as pertains to the employee, etc.*

APPENDIX M

DISCUSSION GUIDE: PARTNERS IN HEALTH

1. The following discussion guide is provided for use when presenting the film *Partners in Health*. It was produced by the Department of Motion Picture Production, Walter Reed Army Institute of Research, with technical direction from the US Army Environmental Hygiene Agency.
2. Running time for the film is 62 minutes.
3. The film provides an introduction to the occupational health program provided civilian and military employees of the Department of Army. It outlines the objectives and scope of services provided and describes the employee's responsibilities within the occupational health program.
4. The proposed audience for the film includes:
 - a. DA employees--both new hires and longer term personnel.
 - b. DA supervisor training courses (health of employee units).
 - c. MEDDAC Health & Environment, occupational health, and other personnel concerned with the occupational health program.
 - d. Basic training courses--enlisted and officer personnel.
 - e. Academy of Health Science Courses:
 - (1) Community Health & Environmental Science (6A-F5).
 - (2) Community & Environmental Health Program Management (6A-F6).
 - (3) Chief Nurses' Orientation (6F-F2).
 - f. Chief Nurses' Conference.
 - g. MEDDAC Commanders' Conference.
 - h. Preventive Medicine Conference.
5. Copies of the film may be requested on DA Form 4103-R, Training - Audiovisual Support Loan Order, from the Army Audio-Visual Support Center.



HSE-OM

DEPARTMENT OF THE ARMY
U S ARMY ENVIRONMENTAL HYGIENE AGENCY
ABERDEEN PROVING GROUND, MARYLAND 21005

30 January 1978

"PARTNERS IN HEALTH"

Film Discussion

1. References:

- a. Public Law (PL) 79-658, Health Programs for Government Employees, as amended [5 US Code (USC) 7901].
- b. PL 91-596. Occupational Safety & Health Act of 1970, 29 December 1970.
- c. Title 29, Code of Federal Regulations (CFR), Part 1960, Safety and Health Provisions for Federal Employees.
- d. Executive Order 11807, Occupational Safety & Health Programs for Federal Employees, 23 September 1974.
- e. Federal Personnel Manual (FPM) Chapter 792, Federal Employees Occupational Health Program.
- f. AR 40-5, Health & Environment, 25 September 1974.

2. Introduction.

a. As one of the larger employers in the nation, the Department of Army has a significant responsibility to assure effective utilization and conservation of this manpower. To meet its share of this responsibility, the Army Medical Department has provided an Occupational Health Service for Army installations since early in World War II. Until recently major emphasis has been placed on having occupational health clinics primarily at US Army Materiel Development & Readiness Command installations, such as Letterkenny Army Depot in Pennsylvania, and Picatinny Arsenal in New Jersey, where the majority of the employees are civilian and many occupational (industrial) hazards exist. Since December 1970, when PL 91-596, Occupational Safety & Health Act (OSHA) of 1970 was passed, emphasis has been given to expanding and improving existing occupational health programs and to establishing occupational health clinics at all other Army installations where civilian employees, as well as military personnel, are exposed to toxic materials and a variety of other noncombat hazardous environmental influences in their duty assignments.

b. The film provides an overview of the Army's occupational health program as required by law and regulation (see references). It focuses on the services provided Army employees to help them stay healthy and protect them from potential health hazards at work. It also emphasizes the employee's responsibilities for protecting his own health through such measures as reporting promptly to the health clinic for care of injuries and for job-related physical examinations. The occupational health program at each installation will vary in accord with the

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SUBJECT: Film Discussion, "Partners In Health"

type of installation and size and scope of occupational health staff and facilities available.

3. Objectives. The viewer will be able to:

- a. Identify the major occupational health services provided Army employees.
- b. Identify responsibilities of the employee to make effective use of the available occupational health services.

4. Points to be observed:

- a. Major services provided employees by the Army occupational health program.
- b. Requirements of employees to report for job-related physical examinations.

5. Show the film - (showing time: 22 minutes).

6. Discussion questions.

a. Question: What is the purpose of the occupational health program?

- Answer: (1) To be sure the worker is physically fit to do his/her job.
(2) To help the worker stay healthy on the job.
(3) To be sure the worker is not harmed by the hazards of the job.

b. Question: What services are included in the occupational health program?

- Answer: (1) Preplacement examinations.
(2) Job-related examinations.
(3) Emergency and followup care of occupational injuries and
(4) Palliative care and referral for nonoccupational illnesses.
(5) Health education and counseling.
(6) Confidential medical records.

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SUBJECT: Film Discussion, "Partners In Health"

- c. Question: What services are not provided in the occupational health program?
- Answer: Definitive treatment of nonoccupational illnesses and injuries.
- d. Question: What are the employee's responsibility within the occupational health Program?
- Answer: (1) Report all injuries and illnesses promptly.
(2) Use protective equipment.
(3) Follow safety procedures.
(4) Initiate compensation forms.
- e. Question: What information is provided the supervisor if the employee visits the clinic?
- Answer: If for job-related examination, fitness for duty examination, occupational illness or injury, only information required for formal reports and/or action. For nonoccupational matters, nothing unless employee requests information be given to supervisor.
- f. Question: Are employees entitled to hospitalization or just clinic services?
- Answer: For occupational illness/injury, employee is entitled to total care. Otherwise, employee would be entitled to one-time clinic care.
- g. Question: Why should employees go to the clinic for minor illnesses and injuries?
- Answer: (1) To get appropriate medical care from qualified personnel.
(2) Symptoms employee could think were minor illness could indicate (or become) a more serious problem.
(3) To ensure proper recording and reporting. If complications occur, this could be important in determining legitimacy of future claims.

APPENDIX N

HOW TO WRITE AN SOP*

N-1. INTRODUCTION.

a. SOP's are organizational tools that provide a foundation for training new employees, for refreshing the memories of management and experienced employees, and for ensuring that important procedures are carried out in a standard, specified way.

b. Too often SOP's are written carelessly and in haste, usually to meet a "boss imposed" requirement for documentation. The result is of little help to the organization if not useless altogether.

c. This guide on How to Write an SOP is designed to help the person who is confronted with the task of writing or revising an SOP. It explains what SOP's are and what they are not, their purpose, indications, and the steps involved in writing them. Also covered are format, content, and common errors in writing SOP's.

d. Use of this guide will provide the prospective writer of an SOP a clearer idea of what lies ahead, thereby enhancing the potential for creating a competently written, useful document.

N-2. DEFINITION AND PURPOSE OF AN SOP.

a. The acronym "SOP" stands for the term "Standing Operating Procedures." An SOP describes--and prescribes--how a procedure is to be performed within an organization. It is a written guide indicating who (by job title) performs the various steps in the procedure, and in what sequence the steps are carried out.

b. The principal function of an SOP is to provide detailed, step-by-step guidance to employees who are required to carry out a certain procedure. In this instance it serves not only as a training aid but also as a means of helping to ensure that the procedure is carried out in a standard, approved manner.

* Extracted from article by Alfred M. Allen, M.D., COL, MC, while serving as Chief, Preventive Medicine Activity, Brooke Army Medical Center, Fort Sam Houston, Texas. March 1980

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c. Another important function of an SOP is to keep management informed about the way functions are performed in areas under their supervision. A complete file of well written, up-to-date SOP is an indication of good management, and provides management with instant access to information on functional details of the organization for which they are responsible. This is of enormous benefit during inspections and management reviews, to say nothing of providing timely answers to unanticipated questions from superiors.

d. Other functions of the SOP are less clear-cut but may be important in certain circumstances. For example, an SOP can be used as an administrative tool to decide where in an organization a function should be carried out, what materiel and personnel resources are required, and how much employee time is expended in carrying out the procedure once it is in operation.

N-3. INDICATIONS FOR AN SOP.

a. Whenever a procedure or an action within an organization is repetitive and is carried out in the same way each time.

b. Whenever it is critically important that a procedure, no matter how seldom performed, be carried out exactly according to detailed, step-wise instructions.

c. Whenever there is a need to standardize the way a procedure is carried out for ensuring quality control or system compatibility.

N-4. STEPS IN WRITING AN SOP.

a. Decide what SOP's must be written based upon a review of organizational functions.

b. Check to see if there is an existing SOP that can be revised or updated.

c. Gather information on the procedure from reference sources and knowledgeable employees. When possible, contact other agencies performing similar functions to see if they have an SOP, and request a copy to use as a guide or source of ideas.

d. Select a suitable format for the SOP to be written. (See para N-5 and fig N-1).

e. Assemble blank forms and any other documents to be referred to in the SOP .

LETTERHEAD

File No. _____ Date Prepared (or Revised) _____

Title

1. Purpose: *(Purpose of the SOP and of the procedure itself.)*
2. Scope: *(Whom is the SOP for? What does the procedure apply to?)*
3. Authority: *(Regulation or direction that calls for procedure to be performed.)*
4. Procedure:
 - a.- z. *(Subheadings: Use to break procedure up into major subprocedures or major components.)*
5. References:

Signature block of preparer

Signature block of approving official

Figure N-1. Suggested SOP outline.

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f. Write a draft of the SOP. Include copies of any blank forms referred to in the SOP.

g. Review or have a fellow employee review the draft SOP for technical adequacy.

h. Request that the draft SOP be reviewed for administrative adequacy by the supervisor or the officer in charge.

i. Incorporate any changes indicated by the reviews into a final draft.

j. Date, sign, assign a file number, and distribute the new or revised SOP. Final copy should be signed both by the official responsible for preparing the SOP and by the official's supervisor or the officer in charge. Copies should be provided to supervisors and officers in charge of the immediate organization, and should be posted in an SOP file for ready reference.

N-5. FORMAT FOR AN SOP. There is no fixed format for an SOP other than a title for purposes of identification and utilization. When a format is decided on, it should be followed for all procedures prepared to provide continuity and ease in use of the SOP. The format outlined in figure N-1 is suitable for most SOP's. When the individual SOP's are compiled into an OHS SOP Manual, arrange them in a logical sequence (e.g., all administrative procedures together, medical surveillance procedures together, etc.). A table of contents is also essential.

N-6. DEVELOPMENT OF SOP CONTENT.

a. The heart of an SOP is the part that specifies which people do each job, and what steps are required to perform the procedure in the prescribed manner.

b. The overridingly important feature of a good SOP is that it communicates what is to be done in a clear, concise, and step-wise manner. The person to whom it must communicate is typically the new employee who may have little or no experience with the procedure in question. Therefore, it is imperative that the writer of an SOP figuratively place himself in the position of a new, inexperienced employee in order to appreciate what must be communicated and how to communicate it.

c. The content of an SOP should be comprehensive in terms of how to get the procedure accomplished, but should not encompass matters not directly relevant to this end. Enumeration of responsibilities in an SOP is an irrelevant digression because it does not directly address the issue of how to get the procedure accomplished and exactly who is to do it.

d. Perhaps the best advice concerning the content of an SOP is this. Ask yourself the question: Does the SOP answer the questions -- Who? What? Where? When? How? If it does, it is complete. If not, revise it until it does in a clear and logical an order as possible.

N-7. COMMON PROBLEMS AND ERRORS IN WRITING AN SOP. The most common problems and errors found in SOP's are summarized in the following list.

a. Enumerating responsibilities for carrying out a procedure rather than stating who does the procedure and how. Regulations are the place for delineating responsibilities, not SOP's.

b. Failure to clearly state who carries out which step in the procedure. The 'Who' is as important as the 'What.'

c. Inclusion of specific steps or procedures performed by persons outside the organization. This information has no place in an SOP because it involves actions which are beyond the direct control of the organization. Include only those steps that are carried out by the employees in the immediate organization. When employee procedures include interactions with individuals outside of the organization, this should be indicated but should not specify the actual steps taken by the other Persons.

d. Vagueness and imprecision. What if the reader of the SOP cannot figure out exactly who (by job title or description) is required to carry out d step in the procedure and furthermore cannot determine precisely how it is to be carried out? Obviously, then, the SOP has failed in its primary objective, communication. This is why a prime function of the reviewer is to check to see if the writer has conveyed the message clearly and unequivocally.

APPENDIX O

OCCUPATIONAL HEALTH CLINIC FACILITIES

0-1. Planning or assessing the adequacy of the OHC facility should be based on the type of installation, type and scope of OHP, the population served, and efficient space utilization. Space needs will vary. One rule of thumb suggests 1 to 1.5 square feet per employee up to 1000 employees, with a lower ratio for larger groups of workers.* Space planning and utilization criteria is available from the Commander, US Army Health Facilities Planning Agency; ATTN: SGFP-ZA, Washington, DC 20310. Guidance on OHS space and facility layout is also available from the Occupancy Guide, Federal Employee Health Units, available from the General Services Administration.

0-2. Factors to consider in provision of an adequate and efficient OHS facility include:

a. Easy access from various areas of the installation, particularly industrial work areas and the personnel office. When the MEDCEN/MEDDAC hospital or TMC provide supporting laboratory and x-ray services, access to them should also be considered in determining the location of the OH clinic.

b. Easy access into and within the OHC for stretchers and wheel chairs, to include easy access for ambulances.

c. Efficient traffic flow patterns for both staff and patients. This should include:

(1) Controlled entrances and exits for the OHS to facilitate prompt and proper care of workers and to be sure it is not used as a pathway for personnel with no need to be in the unit.

(2) Room arrangements that permit efficient use of physician time during examinations, avoid unnecessary undressing and dressing for patients, and allow for logical sequence of examination or treatment procedures.

(3) Equipment placement that permits easy access and operation.

d. Noise control throughout the facility, but with emphasis on the area where audiometry is performed.

* Konzen, Jon L. "Design and Operation of An Occupational Health Program, The Industrial Environment - Its Evaluation and Control _____, USDHEW, 1973, US Government Printing Office, Washington, DC.

e. Good ventilation and temperature controls.

f. Good illumination and adequate electrical outlets for supplementary illumination and electrical equipment.

g. Hot and cold running water and toilet facilities. Location of handwashing facilities should be based on need to maintain aseptic techniques in patient care and examination. Sinks should have foot- or knee-operated faucets. Consideration should be given to having eye lavage attachments on one sink in the clinic facility.

h. Communications requirements include two telephone units with at least one Class A line and one Class C line. An intercom system within the OHS should also be provided when warranted by the size and space layout of the OHS.

i. Engineering or safety controls required by special equipment such as x-ray, electrocardiograph machines, etc.

j. Ease of cleaning and maintenance of the facility.

k. Security for medical record files and other classified records or documents.

l. Employee/patient comfort in waiting room and recovery areas. This should include aesthetic and psychological, as well as physical aspects (e.g., use of color, flowers or plants, pictures, reading materials, etc.).

m. Staff requirements for conferences and lounge and change areas.

n. Supply maintenance.

0-3. Minimum facility requirements include specific areas for patient waiting, treatments, examinations, patient interviewing/counseling, and for OHS administration activities. When no other rest or recovery facilities are available at the installation, this should be provided at the OHS.

0-4. Additional facilities, depending on the needs of the installation and availability of MEDDAC/MEDCEN facilities, may include:

a. Laboratory room.

b. X-Ray room.

c. Physiotherapy room.

d. Special treatment rooms or areas, such as for eye injuries, etc.

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e. Special examination rooms or areas, such as for electrocardiograms, pulmonary function screening, audiograms, vision screening, etc.

f. Storage area for supplies and equipment.

g. Records room.

h. Physician, nurses, and industrial hygienists (if not located in PMA) Offices.

i. Reference library area (this may be combined with staff lounge or the administrative or professional office area).

APPENDIX P

OHS CLINIC EQUIPMENT AND SUPPLIES

P-1. Equipment selection should consider such factors as need, quality and durability (including maintenance requirements), cost, availability of alternate resources, and ease of use and how much training will be required to operate the equipment. Equipment should also meet standards, such as ANSI, etc., where such standards have been promulgated (e.g., audiometers). Equipment includes both furniture and patient treatment or examination items. Recommended industrial hygiene equipment is listed in the USAEHA Industrial Hygiene Evaluation Guide.

a. Basic furniture type equipment requirements may include:

- (1) Desks and chairs, including chairs for the waiting area
- (2) Files with lock (medical and administrative)
- (3) Treatment table, chair, and hand and foot rests
- (4) Examining table with stirrups (may double as a bed)
- (5) Medicine and supply cabinets with locks
- (6) Refrigerator
- (7) Stretcher and wheel chair
- (8) Beam scale and height bar
- (9) X-ray view box
- (10) Bed(s)
- (11) Emergency lights
- (12) Waste receptacles, at least one with cover for dressings
- (13) Bulletin board
- (14) Bookshelves
- (15) Dispensers for adhesive, paper towels, paper cups, soap, etc
- (16) Lockers for staff uniforms

- (17) Portable screen
 - (18) Sterilizing equipment, if sterile supplies are not available elsewhere
- b. Examination and treatment equipment may include:
- (1) Stethoscope
 - (2) Otoscope
 - (3) Ophthalmoscope
 - (4) Sphygmomanometer
 - (5) Audiometer and sound treated examination booth or sound attenuated room
 - (6) Stereoscopic vision screener with Verhoeff stereopter and color vision plates
 - (7) Tonometer
 - (8) Spirometer, if not available elsewhere
 - (9) Slit Lamp
 - (10) Electrocardiograph
 - (11) X-ray machine, if not available elsewhere
 - (12) Laboratory equipment, if not available elsewhere
 - (13) Magnifying light and flashlight
 - (14) Emergency bag (to take to site of injury)
 - (15) Resuscitator and/or Bag Valve Mask (BVM)
 - (16) Defibrillator, if not available elsewhere
 - (17) Ice bag and hot water bottle or thermal equivalents
 - (18) Heat lamp and other physiotherapy equipment (eg, whirlpool, ultrasound, etc), as needed
 - (19) Basins for soaks, etc

- (20) Emesis basin
- (21) Covered dressing containers
- (22) Graduated Measure
- (23) Splints and immobilization equipment; canes and crutches
- (24) Restraints
- (25) Equipment for destruction of disposable needles
- (26) Scissors

P-2. Supplies and medications selection, as with equipment, should consider need, quality, cost, and related factors. They are usually considered to be expendable items.

a. Supplies may be considered in two general categories: administrative (paper, forms, binders, pencils, etc.) and patient care items. The latter should be disposable to the greatest extent possible. The most commonly needed items (excepting administrative items) include:

- (1) Thermometers
- (2) Tongue depressors and applicators
- (3) Tourniquet
- (4) Rubber gloves
- (5) Medicine glasses and medicine droppers
- (6) Bandage, dressings, adhesive, cotton, etc
- (7) Syringes and needles
- (8) Suture equipment
- (9) Towels, drapes, sheets, pillow cases (paper or linen)
- (10) Blanket
- (11) Special treatment trays such as for eye care, anaphylactic shock, minor surgery
- (12) Single and triple-flange earplugs in all available sizes

(13) Airways

(14) Paper bags, cups '

b. Medications should be limited to those designated by the physician and approved by the Therapeutic Agents Board. All controlled drugs will be maintained IAW law and regulation. Chapters 7 and 8, AR 40-2, provide definitive instructions on the procurement and handling of pharmacy items.

APPENDIX Q

GUIDE FOR WRITING POSITION DESCRIPTIONS

FOR OCCUPATIONAL HEALTH NURSES

Q-1. INTRODUCTION. In 1977 the US Civil Service Commission (now Office of Personnel Management) introduced the Factor Evaluation System as a method for determining grades for general schedule jobs. The Factor Evaluation System is designed to assure appropriate grade alignment among occupations and across organizational lines. Each job is divided into nine factors common to all nonsupervisory jobs.

- a. Knowledge required by the position
- b. Supervisory controls
- c. Guidelines
- d. Complexity
- e. Scope and effect
- f. Personal contacts
- g. Purpose of contacts
- h. Physical demands
- i. Work environment

After each factor has been described, it is assigned a numerical score by the Civilian Personnel Officer in line with scores predetermined by OPM. The grade level for the position is then determined by computing the total score and comparing it to the OPM Grade conversion table.

Q-2. THE GS-610 SERIES. The GS-610 series includes all positions for which a professional knowledge of nursing and for which a license to practice as a professional nurse are required. The title of occupational health nurse is used for professional nursing positions, GS-9 and above, which provide nursing and health services to workers in relation to their occupations and work environment. This does not restrict OHN's to working with only civilian employees nor does it mean necessarily that assignment to a clinic facility working primarily with civilian employees means a nurse is an OHN. The position description must be clearly written and evaluated before a determination can be made.

Q-3. DEVELOPMENT OF THE POSITION DESCRIPTION. The position description consists of a listing of the major duties to be performed by the individual and an analysis of each factor in relation to the major duties.

a. Definition of duties. This begins with a general statement about the position and is followed by a more detailed descriptive list of duties to be performed. Following are two examples of the definition of duties. Neither example is all-inclusive.

EXAMPLE 1: Provides professional nursing care in an occupational health clinic.

- a. Obtains medical histories and other pertinent information from patients.
- b. Provides emergency care for illnesses and injuries.
- c. Administers treatments, medications, and immunizations.

EXAMPLE 2: Plans, coordinates, and implements a comprehensive occupational health program for civilian and military employees at _____.

- a. Participates, as the nursing authority, with the consulting physician in developing the approach to health care of employees and formulates policy, objectives, standards, and systems that insure delivery of comprehensive occupational health services that meet pertinent legal and regulatory requirements. Plans and implements the professional nursing role within the program.
- b. Coordinates with the safety officer and other members of the preventive medicine activity to obtain and maintain current data regarding types and location of occupational health hazards and coordinates with the consulting physician to use these data in designing and implementing the job related medical surveillance program.
- c. Develops and implements job-related health education and general health promotion programs.
- d. Makes regular visits to work areas to keep current on work conditions and operations, encourage or advise employees about proper use of protective equipment, and to consult with supervisors or workers as needed.
- e. Maintains occupational health records, collects and assesses data for epidemiological or administrative purposes, prepares or supervises preparation or required reports.

The above examples show that there will be a significant difference in responsibilities and in knowledge and experience needed in order to perform the duties of each position adequately. Actual grading of the positions will depend on the analysis of factors needed to perform each job.

b. Factor Analysis. The nine factors enumerated in paragraph Q-1 must be defined and clearly and concisely written. The description of the duties and the factors must complement each other. Examples of factor level descriptions follow for each factor.

(1) Factor 1, Knowledge required by the position. In describing the knowledge required, identify the type and extent of information the nurse needs in order to do the job. Avoid use of the word ability whenever possible, as well as use of personal characteristic descriptors, such as creativity. Examples:

(a) Knowledge of professional nursing principles, practices, and techniques.

(b) Knowledge of signs, symptoms and causes of occupational illnesses and injuries, and treatment of minor illness and injury.

(c) Knowledge of epidemiologic principles, practices, and application.

(d) Knowledge of the full range of professional occupational health nursing principles, practices and procedures required to organize an efficient and effective occupational health nursing service.

(e) Knowledge of management practices needed to administer a broad nursing program requiring the coordination and cooperation of many individuals.

(f) Ability to counsel and teach individuals, medical professionals, and management personnel.

(g) Knowledge of public health principles used in the assessment and analysis of target population health needs and the design and evaluation of health care delivery systems.

(h) Knowledge of legislative and regulatory requirements governing the operation of a comprehensive occupational health program.

As can be seen, some of the above levels of knowledge would not be required for the nurse working in a clinic setting who would not be responsible for administration and evaluation of an occupational health program, but would be involved primarily in responding to the needs of clinic patients.

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(2) Factor 2, Supervisory controls. In developing the statement of supervisory controls, three subfactors must be considered: the level of direct or indirect supervision under which the nurse works, what is the employee's responsibility for carrying out the work, and how the work is reviewed. Examples:

(a) Works under supervising nurse who gives detailed instructions for new or unusual assignments. Uses initiative and judgment in performing routine work but refers deviations to supervisor. Work is reviewed for technical soundness, or

(b) Policy direction is provided by the Chief, Preventive Medicine Activity, who delegates to the incumbent the responsibility for planning, designing and implementing the occupational health program. Medical guidance is provided by the assigned consulting physician. Work is reviewed for fulfillment of program objectives and effectiveness of the overall occupational health program.

(3) Factor 3, Guidelines. Subfactors to be considered are: what guidelines are available for performing the work and the judgment needed to apply the guidelines or develop new guides. Examples:

(a) Works within established policies and procedures which cover most, but not all, situations. Judgment is required to determine course of action in emergency situations and in determining whether to treat patient in the clinic or refer to another facility, or

(b) Works within established Army and other Federal and installation policies and regulations which do not cover every circumstance. Participates in the development of local regulations and standing operating procedures for occupational health program implementation. Uses judgment in interpreting and adapting guidelines to the situation.

(4) Factor 4, Complexity. Subfactors to be evaluated include the nature, quantity, variety, and intricacy of work performed; the difficulty in identifying what needs to be done; and the difficulty of and originality required in performing the work. Examples:

(a) Work consists of routine nursing actions to obtain health histories, assist in physical examinations, provide treatment for minor problems, and counsel and provide health education for employees/patients, or

(b) The work is an independent assignment, requiring the nurse to combine advanced administrative and organizational skills and the full range of occupational health nursing knowledge in designing and implementing diversified program elements. The program requires constant analysis to evaluate effectiveness, responsiveness to worker population health needs and cost efficiency.

(5) Factor 5, Scope and effect. This factor involves the purpose, breadth and depth of the assignment, and the effect of services provided. Example: Plans, develops, implements, and evaluates occupational health services and programs. The program supports, and therefore affects all civilian and military employees.

(6) Factor 6, Personal contacts. Included as contacts are face-to-face and telephonic communication with persons not in the supervisory chain. (The relationship of factors 6 and 7 presumes the same contacts will be evaluated for both factors.) Examples:

(a) Personal contacts are with employees and supervisors, or

(b) Personal contacts are with all levels of medical and nonmedical personnel (employees, supervisors, management personnel) within the installation and with representatives of local/community health care providers and agencies.

(7) Factor 7, Purpose of contacts. Purpose of contacts may involve simple exchange of information, coordination of work efforts, influencing of motivating persons or groups, or negotiating controversial issues. Most nurse positions will be at the level of influencing or motivating persons or groups. Such contacts may require a high degree of skill. Examples:

(a) Personal contacts are to treat patients and to influence and motivate them to develop and maintain good health habits, or

(b) Contacts with patients and supervisors are to orient them to the occupational health program and encourage and promote health regimens in an effort to improve health. Contacts with other professionals, management, and community leaders are to influence policy formulation and program support as related to worker health.

(8) Factor 8, Physical demands. This factor involves the requirements and physical demands placed on the nurse by the work assignment. Examples:

(a) Work requires considerable standing, walking, and occasional lifting of patients, or

(b) The work requires walking; standing; and climbing in, traveling to, and visiting a variety of military work areas.

(9) Factor 9, Work environment. To be considered are the risks and discomforts which may be imposed by physical surroundings or job situations. Examples:

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(a) Works in a clean health unit with some exposure to infectious disease, or

(b) Works in a clean health unit with some exposure to infectious disease and visits all work areas of the installation where a variety of hazards are encountered. Is required to utilize protective equipment during potential exposure to noise, vision, biological, chemical, or radiological health hazards.

APPENDIX R

EXAMPLES OF PERFORMANCE STANDARD STATEMENTS

R-1. Specific guidance for writing performance standard statements is available from the Civilian Personnel Office. This guidance is provided through training courses for supervisors and printed guides. These guides are comprehensive and offer valuable assistance in defining major/critical job elements, delineating tasks, establishing standards of performance, and conducting performance appraisals.

R-2. Figures R-1 through R-4 present sample performance standard statements that might be used for certain functions of selected occupational health staff members. They are not all inclusive for any position, job element, or task. Additional examples may be available from the CPO.

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OCUPATIONAL HEALTH PHYSICIAN

Major/Critical Elements	Supporting Tasks	Performance Standards
Inventory of Health Hazards	Reviews hazard inventory.	Medical review of hazard inventory is completed annually and documented (inventory signed, dated by OHP); LDHHL medical reviews for new facilities or operations are completed within 5 working days after receipt of LDHHL.
Determines placement, periodic, and termination job-related medical surveillance.	Determines placement, periodic, and termination job-related medical surveillance.	Medical monitoring requirement (or nonrequirement) is documented for each exposure and/or position requiring a level of physical fitness; determinations are based on appropriate laws, regulations, the USARA Medical Surveillance Guide or other recognized professional references, and good medical practice; monitoring requirements include frequency and content of examinations and are related to the extent of the exposure.
Visits Work Areas.	Visits Work Areas.	Visits all areas known to have hazardous exposures at least annually and other areas at least every 2 years; is informed about work operations, and maintains liaison with supervisors, safety officers, and workers.
Health Examinations	Performs placement, periodic and termination job-related examination.	Priorities for performing examinations are based on severity of potential exposure and require-ment for medical input; where appropriate, limits medical input to review and action on results of medical monitoring conducted by other OHC Staff; examination findings are documented IAW established procedures; referrals to specialists or other recommended followup of examination findings are specific as to purpose and assistance/action desired.
Occupational Health Program Direction	Directs development and maintenance of all program SOP.	SOP are available for all OHC activities and programs; the format is IAW established standards and SOP are organized in a way that facilitates their use for day to day operations and program evaluation; they are reviewed and updated annually and so documented by the OHPD.
Provides medical directives for treatment of patients by OHC staff and supervises staff members who are categorically credentialled.	Provides medical directives for treatment of patients by OHC staff and supervises staff members who are categorically credentialled.	Medical directives cover all commonly provided treatments; are appropriate to the qualifications of the staff; are IAW established NRC/DOE IAW and other policy; are reviewed and updated annually and/or as staff changes or other changes dictate.
		Credentialing supervisory authority is specific; IAW established policy; appropriate to the qualifications and responsibilities of individuals who are categorically credentialled; is reviewed annually, and is documented in writing, signed, and dated.

OCCUPATIONAL HEALTH NURSE	
<u>Major/Critical Element</u>	<u>Supporting Tasks</u>
Occupational Health Program Plans and Evaluation	<p>Prepares program document.</p> <p>Conducts program evaluation.</p> <p>Evaluation is based on stated objectives and is ongoing; administrative and medical records and reports are used to document OHS program accomplishments. Epidemiological investigations, and other pertinent evaluation data. OHS program/activity changes indicated by ongoing evaluation are initiated as feasible. The annual program evaluation addresses all program objectives, identifies those that have been met fully, partially, or not at all and states, factually, reasons for partial or nonaccomplishment of objectives.</p>
Program Administration	<p>Establishes and maintains scheduling, referral, and followup systems for medical examination program.</p> <p>Personnel scheduled for examinations do not wait more than 10 minutes before processing begins and between each element of the examination; schedules are coordinated with laboratory and other MIF facilities to fit within their work loads.</p> <p>Referrals are specific and assistance in making appointments is given if needed; followup suspenses are related to anticipated response to the referral or urgency of the problem.</p>
Patient Care	<p>Provides nursing treatment of minor illness and injury.</p> <p>Assessment and treatment of all injuries and illnesses is IAH established nursing practices, OHS SOP, and signed medical directives; recording of treatments is complete IAH established standards and procedures, signed, and dated.</p> <p>Identifies when 2 or 3 persons from the same work location present similar symptoms or injuries and confers with the OIHO, Industrial Hygienist, and/or safety to identify and correct potential OH problems.</p>
	<p><u>Performance Standard</u></p> <p>Assessment of OH program needs is coordinated with OIHO Consultant, PMA, IH, and others as indicated; objectives are based on the mission, factual documentation of needs (hazard inventory, occupational illness or injury incidence, population data, etc.), and available or projected resources.</p>

Figure R-2. Occupational Health Nurse Performance Standard Statements

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<u>Major/Critical Element</u>	<u>Supporting Tasks</u>	<u>Performance Standard</u>
Prevention of Occupational Illness and Injury	Refers to or consults with the physician or other health care resources on patients with serious or unusual symptoms.	Referrals or consultations are made promptly for medical directives and the urgency of the symptoms. Advisability of the referral is questioned in no more than 3-5 percent of the cases. Referral sources are provided with comprehensive data about the cause, symptoms and treatment given and assistance or consultation desired, using approved IA or other standard forms. Suspense dates for followup are set and followed, when indicated. All pertinent information is entered in the patient record.
Prevention of Occupational Illness and Injury	In coordination with IH and OSHA, identifies personnel working in health hazardous areas and promotes elimination or control of hazards and use of protective measures for employees.	OHS inventory of civilian and military personnel working with health hazards is 90-95 percent complete and current. Visits every worksite at least once annually. Priority for other worksite visits is given to areas with critical hazards or where there is low supervisor/employee compliance with use of protective equipment. Documents all worksite visits, including observations made during visits.
Health examinations	Coordinates and/or conducts initial and periodic job-related health examinations.	95 percent of all new light duty employees are given a baseline health evaluation; abnormal findings are referred to employee's personal physician, results and counsel given are documented in established procedures.
Health examinations		95 percent of all civilian and military personnel working in health hazard areas are scheduled for the periodic medical surveillance within 1 month of the projected suspense date. Screening tests are performed in standard test procedures and specific hazard exposures of the job. Findings are documented in established recording procedures as soon as the test is completed. Referral for laboratory, x-ray, or other procedures conducted at other MTF facilities clearly document the reason for the referral.

OCCUPATIONAL HEALTH TECHNICIAN	
<u>Major/Critical Elements</u>	<u>Performance Standards</u>
<u>Suggesting Tasks</u>	
<p>Performs screening tests.</p>	<p>Tests are administered in accordance with established procedures, employees understand reason for tests and instructions, with 90 percent completing the test within the average time frame; recording of results is at least 98 percent accurate; equipment is maintained so only routine or age-related repairs are required; all abnormal results are double checked and referred to the OMM or OMMO before completing the examination; statistics are maintained for report purposes.</p>
<p>Fits and/or advises regarding use and care of personal protective equipment.</p>	<p>All new employees in noise hazard areas are fitted with hearing protectors. (As established procedures, before they begin their job); all personnel coming for periodic audiograms are checked regarding fit and use of hearing protectors and are refitted if necessary; all personnel are instructed in use and care (cleaning, signs of deterioration, etc.) of hearing and vision protective equipment; during worksite visits employees are observed for use of protective equipment; misuse is discussed with employee and supervisor.</p>
<p>Occupational Health Records</p>	<p>Records are initiated for each employee at the time of first visit to the OHS IAW established procedure; recording of patient visits contains all pertinent data, is clear and concise, and signed and dated; records are filed NLT end of day of visit and IAW filing procedures.</p>

Figure R-3. Occupational Health Technician Performance Standard Statements

<u>CLERK-TYPEWRITER</u>	
<u>Major/Critical Element</u>	<u>Supporting Tasks</u>
General Clerical Support	Types letters, indorsements, memoranda, and narrative reports from dictation and rough drafts/longhand and typed.
	Answers telephone inquiries of routine nature, receives clinic visitors.
	Follows prescribed military correspondence procedures with no more than three-six procedural errors per year; consistently prepares the correct number of copies, all copies are proofread and properly arranged for signature.
	All work is completed within 1-2 days after dictated or before suspense deadline.
	Not more than 3-5 percent of work units are returned for errors in spelling, punctuation, format. Features are clean, margins are even.
	Uses established telephone procedures, gives correct information courteously, refers nonroutine or professional calls to proper person immediately, delivers all telephone messages.
	Refers all clinic visitors to the proper OMS staff person IAW OMS procedures, advises visitors of any delays in referral and the reason for this.

Performance Standard

Figure R-4. Clerk-Stenographer Performance Standard Statements

APPENDIX S

RECOMMENDED AREAS OF KNOWLEDGE
FOR THE OCCUPATIONAL HEALTH PHYSICIAN

The following areas of knowledge recommended as essential to the OHMD, are based on the topics covered in the certifying examination in occupational medicine as outlined by the American Board of Preventive Medicine:

- a. **Clinical Occupational Medicine** (*medical surveillance examinations, illness absenteeism, diagnosis and treatment, health education, etc.*)
- b. **Clinical Toxicology and Occupational Diseases** (*toxicological factors of diseases caused by occupational exposures.*)
- c. **Clinical Preventive Medicine** (*adult health, maternal and child health, acute and chronic disease, rehabilitation, immunology, occupational health, etc.*)
- d. **Epidemiology** (*theory, methods, occupational disease, other disease classifications, accidents, etc.*)
- e. **Environmental Hygiene** (*physical and chemical environment and industrial hygiene methods.*)
- f. **Occupational Medicine Program Administration** (*scope and objectives, staff functions and organization, records, workmen's compensation, safety, education and training, etc.*)
- g. **Administration** (*theory, methods, program planning and evaluation, organization and personnel management, economics, legal aspects, etc.*)
- h. **Biometrics** (*statistical analysis of occupational health problems*)
- i. **Environmental Health** (*air, water, waste disposal, industrial hygiene, radiation, etc.*)

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APPENDIX T

AOA CODE OF ETHICAL CONDUCT FOR PHYSICIANS
PROVIDING OCCUPATIONAL MEDICAL SERVICES
(Adopted by the Board of Directors of the
American Occupational Medical Association, July 23, 1976)

F-1. The principles are intended to aid physicians in maintaining ethical conduct in providing occupational medical service. They are standards to guide physicians in their relationships with the individuals they serve, with employers and workers' representatives, with colleagues in the health professions, and with the public.

F-2. Physicians should:

a. Accord highest priority to the health and safety of the individual in the workplace;

b. Practice on a scientific basis with objectivity and integrity;

c. Make or endorse only statements which reflect their observations or honest opinion;

d. Actively oppose and strive to correct unethical conduct in relation to occupational health service;

e. Avoid allowing their medical judgment to be influenced by any conflict of interest;

f. Strive conscientiously to become familiar with the medical fitness requirements, the environment and the hazards of the work done by those they serve, and with the health and safety aspects of the products and operations involved;

g. Treat as confidential whatever is learned about individuals served, releasing information only when required by law or by overriding public health considerations, or to other physicians at the request of the individual according to traditional medical ethical practice; and should recognize that employers are entitled to counsel about the medical fitness of individuals in relation to work, but are not entitled to diagnoses or details of a specific nature;

h. Strive continually to improve medical knowledge, and should communicate information about health hazards in timely and effective fashion to individuals or groups potentially affected, and make appropriate reports to the scientific community;

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i. Communicate understandably to those they serve any significant observations about their health, recommending further study, counsel or treatment when indicated;

j. Seek consultation concerning the individual or the workplace whenever indicated;

k. Cooperate with Governmental health personnel and agencies, and foster and maintain sound ethical relationships with other members of the health professions; and

l. Avoid solicitation of the use of their services by making claims, offering testimonials, or implying results which may not be achieved, but they may appropriately advise colleagues and others of services available.

APPENDIX U

AMERICAN ASSOCIATION OF
OCCUPATIONAL HEALTH NURSES
CODE OF ETHICS

U-1. This code of ethics has been developed to guide the occupational health nurse to maintain ethical conduct in providing occupational health nursing services.

U-2. Occupational health nurses should:

a. Provide nursing service in the work environment with respect for the dignity of man, unrestricted by consideration of nationality, race, creed, color or status.

b. Safeguard the employee's right to privacy by protecting information of a confidential nature; releasing information only as required by law or upon written consent of the employee.

c. Maintain individual competence in occupational health nursing practice, recognizing and accepting responsibility for individual actions and judgment.

d. Act to safeguard the health and safety of the employee in the work environment.

e. Use individual competence as a criterion in accepting and assigning responsibilities.

f. Participate in research and case finding activities related to occupational health when assured the employee's rights are protected.

g. Contribute to the efforts of the profession to define and upgrade standards of occupational health nursing practice and education.

h. Participate actively in the establishment of standards for competent occupational health nursing services through the specialty professional nursing organization.

i. Cooperate with community health agencies and maintain sound ethical relationships with members of allied health professions.

j. Refrain from allowing their names to be used in connection with the advertisement of products or with any other forms of self advertisement.

APPENDIX V

MEMORANDUMS OF UNDERSTANDING BETWEEN
HEADQUARTERS, MACOM
AND
HEADQUARTERS, UNITED STATES ARMY HEALTH SERVICES COMMAND

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Section I

MEMORANDUM OF UNDERSTANDING
BETWEEN
HEADQUARTERS, UNITED STATES ARMY
MATERIEL DEVELOPMENT AND READINESS COMMAND
AND
HEADQUARTERS, UNITED STATES ARMY HEALTH SERVICES COMMAND

1. Purpose. To outline a general agreement as to mutual support and to delineate and clarify relationships between United States Army Materiel Development and Readiness Command (DARCOM) installations/activities and Medical Center (MEDCEN)/Medical Department Activity (MEDDAC). . . .

4. General Policies .

a. The policies contained herein will govern DARCOM/HSC intraservice support agreements which will be executed at the lowest command level practicable. Except under unusual circumstances, this memorandum will serve to standardize command and support agreements between host installations and tenant units. The installation commander will be responsible for the development and accomplishment of Intraservice Support Agreements negotiated in accordance with concepts agreed to herein. . . .

d. Cdr, HSC has established a rating scheme for MEDCEN/MEDDAC commanders, Directors, Health Services (DHS), and Directors of Dental Services (DDS), in accordance with AR 623-105. . . . The mutual goal is to establish a rating scheme which, wherever feasible, provides for the installation commander to rate the DHS/DDS.

e. The MEDCEN/MEDDAC commander will visit, at least once quarterly, every DARCOM installation supported by the MEDCEN/MEDDAC. MEDCEN/MEDDAC and installation commanders will interchange appropriate command information.

f. MEDCEN/MEDDAC commanders will have a dual role:

(1) To command assigned TDA medical units and,

(2) To serve as, or designate, the installation Director, Health Services. At locations where an Army Health Clinic or a civilian employee health clinic provides health services, the chief of that clinic will serve as the DHS. . . .

h. Manpower surveys of medical activities will be made by HQ, HSC, in coordination with DARCOM. Utilization of AMEDD/nonAMEDD TOW personnel will be reflected in the section titled "other" on manpower authorization documents after coordinating with HQ, DARCOM.

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j. Contingency operations and emergency plans which impact on and/or are impacted by medical support will:

(1) If installation oriented, be mutually supported IAW local requirements.

(2) If command-wide and mission oriented, be supported as directed by HQDA. .

m. Installation services outlined in Section XII, Base Operations, AR 37-100-XX (except medical materiel/medical equipment maintenance) will be provided by the host installation. HSC will be provided BASOPS on a non-reimbursable basis.

n. Subject to the priorities listed in figure 2-1, AR 40-3, and to the maximum extent possible, MEDCEN/MEDDAC will provide or arrange for health care services authorized by AR 40-3 and AR 40-5 to all eligible personnel on a non-reimbursable basis. These services are provided in accordance with existing laws and implementing regulations which state that medical care to certain beneficiaries is subject to the Medical Treatment Facility (MTF) commander's conclusive determination as to the availability of space and facilities and the capabilities of the medical and dental staff; and cannot interfere with the primary mission of the facility concerned. Whenever it is necessary to deny care to any category of beneficiary, the MTF commander will inform the local installation commander and inform HQ, US Army Health Services Command (HSC).

o. MEDCEN/MEDDAC will plan, budget and program training for medical personnel supporting the Chemical Agency Surety and Nuclear Surety Programs at appropriate DARCOM installations. MEDCEN/MEDDAC will participate in surety exercises, tests and training within mission assigned capabilities. MEDCEN/MEDDAC/DHS, as appropriate, will provide a physician knowledgeable in chemical agent diagnosis and treatment to participate in the technical investigation of any chemical agent accident/incident which necessitates medical treatment of personnel.

p. Health and Environment Programs for DARCOM activities and installations will be evaluated for completeness, effectiveness, and appropriateness by DARCOM and HSC representatives, to include mutually agreed upon support by the US Army Environmental Hygiene Agency (USAEHA). Requests for support from USAEHA at DARCOM installations/activities will be originated by or coordinated with the local supporting medical authority (paragraph 1-3, AR 40-5), and forwarded through HQ, DARCOM (DRCSG) to HQ, HSC (HSPA-H). . . .

q. HSC/MEDCEN/MEDDAC/DHS will provide consultation to DARCOM commanders relative to healthful working conditions for military personnel and DA civilian employees; conduct field monitoring and special studies to evaluate potential health hazards to insure that places and conditions of employment are consistent with the health standards promulgated under the provisions of Section 6, OSHA (PL 91-596), and will provide other medical requirements as set forth in Public Law 91-596. In addition, HSC/MEDCEN/MEDDAC/DHS will provide the required data for OSHA reports to local safety personnel on statistical data regarding OSHA accidental injury, illness, and loss as directed and required by HQDA. However, it is the responsibility of these medical units to evaluate all suspected and actual cases of occupational illnesses and recommend necessary corrective action. These medical units will work closely and cooperate fully with DARCOM safety personnel at all levels to ensure that the Army's Occupational Safety and Health Programs are successful. Medical requirements generated by DARCOM programs, directives or regulations will be referred by HQ, DARCOM (DRCSG) to HQ, HSC (HSOP) for approval prior to commitment of HSC resources.

r. Medical materiel storage and maintenance facilities are essential components to a modern health care delivery system. DARCOM will provide facilities which will be proximate to the medical treatment facility and permit storage of medical materiel requiring special handling, requisite security, provide protection from the elements, and allow for proper and safe use of materiel handling equipment.

s. Necessary host facility maintenance engineering, manpower resources and funds will be allocated to accomplish medical facility maintenance to insure that the MEDCEN/MEDDAC is in compliance with standards promulgated under the Occupational Safety and Health Act (OSHA), the Joint Commission on Accreditation of Hospitals (JCAH), other applicable Federal, State and local safety and health standards, and safety and health directives directed by HQDA. The compliance with OSHA standards of facilities which are owned by the host and occupied by tenant HSC/MEDCEN/MEDDAC will be the responsibility of the host on an equal priority with all other host OSHA compliance actions.

t. Medical materiel requirements of MEDCEN/MEDDAC located on a DARCOM installation will be supported by the appropriate DARCOM Inventory Manager. Responsibility for budgeting, programing and reporting in terms of support to HSC activities is vested in the DARCOM Inventory Manager. Responsibility for development of medical materiel data for inclusion in DARCOM budgets is vested in the Commander, HSC. At installation level, this responsibility will be exercised by the MEDCEN/MEDDAC. HSC medical activities located on DARCOM installations may prepare the medical portion of the DARCOM installation's program/budget based upon guidance furnished by the installation. The DARCOM installation inventory manager will forward copies of the medical portion of the installation program budget to Commander, HQ, HSC, ATTN: HSLO-M, at the same time that the total installation/program budget is forwarded to DARCOM.

v. Medical Construction Projects.

(1) In accordance with AR 37-49, tenant will budget, fund and reimburse the host for all minor construction (Z Account .L1000) when the tenant's peculiar mission generates, and therefore justifies the project. This exception applies only to real property facilities assigned to the tenant for its exclusive use. .

(2) HSC tenant activities will obtain project approval from the host installation/MACOM for all OMA funded minor construction projects. Projects that are determined to be mission peculiar and require HSC funding should be submitted through medical channels to this headquarters, ATTN: HSCM-P, once approval has been obtained and design completed. . . .

x. The Drug and Alcohol Abuse Control Program will continue to be an installation commander's responsibility with the MEDCEN/MEDDAC commander providing direct support for this function, in accordance with AR 40-5 and AR 600-85.

(6) Inspections of Personnel Reliability Program:

(a) Detailed DARCOM Inspectors General will be authorized direct access to the medical records of DARCOM personnel in the Personnel Reliability Program maintained by a HSC Medical Treatment Facility (MTF). This access is granted for the purpose of evaluating administrative compliance with AR 50-5.

(b) The HSC IG will place emphasis on the medical support role to the Nuclear Surety Program while inspecting HSC MTF that support DARCOM organizations and activities having a nuclear mission.

dd. DARCOM host Data Processing Installations (DPI) will provide the tenant MEDCEN/MEDDAC the ADP support for such Standard Army Multicommand Management Information Systems and Interim DA Standard Systems for participating MEDCEN/MEDDAC as are within the limits of ADP capability. Additional ADP support for HSC approved AMEDD installation unique requirements will be contingent on the availability of DPI resources and will be locally negotiated. .

hh. Commanders of DARCOM installations not having a MEDCEN/MEDDAC activity on post will coordinate and resolve problems of medical support with the MEDCEN/MEDDAC commander having the area support responsibility for the health service area in which the DARCOM installation is located.

Section II

MEMORANDUM OF UNDERSTANDING
AMONG THE
COMMANDER, US ARMY FORCES COMMAND
COMMANDER, US ARMY TRAINING AND DOCTRINE COMMAND
AND
COMMANDER, US ARMY HEALTH SERVICES COMMAND

1. Purpose. To provide an agreed upon basis for the relationship among the Commander, US Army Forces Command (FORSCOM), Commander US Army Training and Doctrine Command (TRADOC), and the Commander, US Army Health Services Command (HSC), concerning elements of their respective commands at the installation level.

4. Objectives. The objectives of this memorandum are to:

a. Identify responsibilities and establish relationships applicable to the Commander, FORSCOM, and Commander, TRADOC, as major commanders of installations and units/activities in their respective areas of responsibility, and Commander, HSC, as a major commander of medical activities tenanted on FORSCOM and TRADOC installations, and as the single manager for the health care delivery system in his specified geographical areas of responsibility.

5. General Policies.

a. Commander, FORSCOM, will command all Active Component AMEDD TOE and USAR AMEDD TOE/TDA units, and supervise the training of all ARNG AMEDD units within FORSCOM's geographical area of responsibility.

b. Commander, HSC, will command all Active Component AMEDD TDA activities within HSC's geographical area of responsibility except those field operating agencies of The Surgeon General, DA.

d. The policies contained herein will govern FORSCOM/TRADOC/HSC ISSAs, which will be executed at the lowest command level practicable. Except for unusual circumstances, this memorandum will serve to standardize command and support agreements between host installation and tenant units. The installation commander will be responsible for the development and accomplishment of ISSA negotiated in accordance with policies established herein.

e. Base operations support furnished on a nonreimbursable basis need not be supported by negotiated written agreements.

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f. MOUs, ISSAs, or other documents of agreement generated at the installation and addressing subjects of this MOU will be forwarded to FORSCOM and/or TRADOC for review/comment prior to implementation.

g. Installation services outlined in Section XII, Base Operations, AR 37-100-XX (except medical material/medical equipment maintenance, and procurement of medical material at MTFs), will be provided by the host installation IAW AR 210-10. Reimbursement for such support will be governed by the provisions of AR 37-49.

6. Operating Procedure .

a. Commander, Health Services Command, IAW AR 5-9, AR 10-43, AR 40-3, and AR 40-5, will provide for total health services within his geographic area of responsibility.

(1) To the maximum extent possible, subject to the priorities listed in Figure 2-1, AR 40-3, MEDDAC/MEDCEN will provide or arrange for health care services authorized by AR 40-3 and AR 40-5 to all eligible personnel on a nonreimbursable basis. These services are provided IAW existing laws and implementing regulations which state that the degree of medical care delivered to certain beneficiaries is subject to the Medical Treatment Facility (MTF) Commander's conclusive determination as to the availability of space and facilities, and the capabilities of the medical and/or dental staff; and, the provision of such services cannot interfere with the primary mission of the facility concerned. Whenever it is necessary to deny care to any category of beneficiary, the MTF Commander will inform the local installation commander and HQ, HSC. . . .

(4) Installation Health Care Services provided by HSC in fixed AMEDD facilities are defined in Section II, AR 40-4. Installation medical service does not include non-fixed medical treatment facilities identified in Section III, AR 40-4.

(5) The commander of the installation Medical Department Activity (MEDDAC) or Medical Center (MEDCEN) will have a dual role.

(a) To command assigned HSC TDA medical unit/activity, and

(b) To serve as, or designate, the installation Director of Health Services (DHS). At locations where an Army Health Clinic or Civilian Employee Health Clinic provides health services, the chief of that clinic will serve as the DHS. . . .

(7) Commander, HSC has established a rating scheme for MEDDAC/MEDCEN Commanders; Directors of Health Services (OHS); and Directors of Dental Services (DDS) IAW AR 623-105.

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b. Active Component (AC) TOE unit resource utilization.

(1) TOE medical units have the normal STRAF, REFORGER, Special Mission Force requirement to maintain combat readiness. In addition to unit training, TOE medical units and individual personnel may assist in and provide support to the local MEDDAC/MEDCEN. . . .

(a) TOE units will not operate, or establish on an installation, any fixed medical treatment facility, e.g., dispensary, clinic, etc.

(b) TOE units may "staff" HSC fixed Medical Treatment Facilities (MTFs) when such staffing does not exceed the MTF's authorized TDA manning levels for military personnel. .

(2) Troop Medical Clinics (TMC) are operated on an installation IAW Section II. paragraph 9a, AR 40-4. .

(3) Under conditions of local civil disaster or medical emergency, installation commander(s) may task the MEDDAC/MEDCEN for professional assistance necessary to accomplish the disaster/emergency relief mission.

(4) Emergency Medical Team (EMT) support to nuclear weapon accident and incident control (NAICP) and similar local contingencies will place primary reliance on the utilization of TOE resources, though MEDDAC/MEDCEN resources may be tasked with prior coordination after exhausting installation TOE resources. . . .

(1) Medical construction projects.

(a) In accordance with AR 37-49, tenant will budget, fund and reimburse the host for all minor construction (Z Account .L1000) when the tenant's peculiar mission generates and, therefore, justifies the project. This policy applies only to real property facilities assigned to the tenant for its exclusive use. .

(b) HSC tenant activities will obtain project approval from the host installation/MACOM for all OMA funded minor construction projects. Funded costs of such minor construction projects will not exceed \$75,000. Projects with a unit cost of \$5,000 or more, determined to be mission peculiar and requiring HSC funding, will be submitted through medical channels to the US Army Health Services Command, ATTN: HSCM-P, when approval has been obtained and design completed.

(c) Urgent minor construction projects IAW AR 415-35, related to construction category 500, will be forwarded from installations to HSC for medical technical review and approval. HSC will then forward the projects through FORSCOM/TRADOC for engineering technical review and forwarding to HQDA for approval....

(2) Maintenance and repair. The Facilities Engineer provides engineering support commensurate with available resources to accomplish medical facility maintenance and repair to insure that the MEDDAC/MEDCEN is in compliance with standards promulgated under the Occupational Safety and Health Act (OSHA); the Joint Commission on Accreditation of Hospitals (JCAH); other applicable federal, state, and local safety and health standards; and safety and health directives of HQDA. Compliance with OSHA standards by facilities which are owned by the host, but occupied by tenant HSC/MEDDAC/MEDCEN, will be the responsibility of the host on an equal priority with all other OSHA compliance actions. . . .

e. Health and environmental programs.

(1) Health and environmental programs of FORSCOM/TRADOC activities and installations will be evaluated for completeness, effectiveness and appropriateness by FORSCOM/TRADOC and HSC representatives, to include mutually agreed upon support by the US Army Environmental Hygiene Agency (USAEHA). Requests for support from USAEHA at FORSCOM/TRADOC installations/activities will be originated by or coordinated with the local installation DHS (paragraph 1-3, AR 40-5), and forwarded through HQ, FORSCOM (AFMD) or HQ, TRADOC (ATMD) to HQ, HSC (HSPA-H). The FORSCOM/TRADOC installation DHS will determine if requested services can be provided by the supporting MEDDAC/MEDCEN.

(2) HSC/MEDDAC/MEDCEN/DHS/DOS will provide consultation to FORSCOM/TRADOC Commanders relative to healthful working conditions for military personnel, DA civilian employees, and other eligible civilian personnel IAW Chapter 4, AR 40-5; conduct field monitoring and special studies to evaluate potential health hazards to insure that places and conditions of employment are consistent with the health standards promulgated under the provisions of Section 6, OSHA (PL 91-596), and will provide other medical requirements as set forth in Public Law 91-596. In addition, HSC/MEDDAC/MEDCEN/DHS/DDS will provide the data required for OSHA reports, regarding OSHA accidental injury, illness and loss to local safety personnel, as directed and required by HQDA. However, it is the responsibility of these medical units to evaluate all suspected and actual cases of occupational illnesses and recommend necessary corrective action. These medical units will work closely and cooperate fully with FORSCOM/TRADOC safety personnel at all levels, to ensure that the Army's Occupational Safety and Health Programs, directives, or regulations will be referred by FORSCOM (AFMD) or TRADOC (ATMD) to HSC (HSOP) for approval prior to commitment of HSC resources

f. Medical materiel.

(1) Medical materiel requirements of MEDDAC/MEDCEN located on FORSCOM/TRADOC installations will be supported by the FORSCOM/TRADOC Army Stock Fund as appropriate. Responsibility for budgeting, programming, and reporting, regarding support of HSC activities, is vested in the Chief, FORSCOM/TRADOC Division, Army Stock Fund. Responsibility for development of medical materiel data for inclusion in FORSCOM/TRADOC stock fund budgets is vested in the Commander, HSC. At installation level, this responsibility will be exercised by the MEDDAC/MEDCEN. HSC activities located on FORSCOM/TRADOC installations may prepare the medical materiel portion of the installation's stock fund program/budget based upon guidance furnished by the installation. The installation stock fund manager will forward copies of the medical portion of the installation program/budget to Commander, HSC, ATTN: HSLO-M, Ft Sam Houston, Texas 78234, the same time that the total installation program/budget is forwarded to FORSCOM/TRADOC. . . .

(3) Medical materiel storage and maintenance facilities are essential components of a modern health care delivery system. FORSCOM/TRADOC will provide facilities which are proximal to the medical treatment facility and permit storage of medical materiel requiring special handling, security, and protection from the elements, and allow for the proper and safe use of materiel handling equipment. .

g. Personnel support.

(1) AMEDD officer personnel will not be diverted or reassigned to the activity of another major command except by direction of The Surgeon General, DA. AMEDD enlisted personnel will not be reassigned to the activity of another major command except by approval of the Military Personnel Center (MILPERCEN), DA.

(4) The Drug and Alcohol Abuse Control Program, an installation commander's responsibility, is directly supported by the MEDDAC/MEDCEN Commander IAW AR 40-S and AR 600-85. HSC allocates sufficient resources to the MEDDAC/MEDCEN to insure mission accomplishment. .

j. Management Information System (MIS) support.

(1) FORSCOM/TRADOC host Data Processing Installations (DPI) will provide the tenant MEDDAC/MEDCEN with ADP support for all Standard Army Multi-Command Management Information Systems (STAMMIS), Interim DA Standard Systems. Additional ADP support for HSC-approved command-unique and AMEDD installation-unique requirements will be contingent on the availability of DPI resources and will be locally negotiated, subject to APD capability provided by HQDA, in accordance with AR 18-1.

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(2) FORSCOM/TRADOC installations will provide timely ADP support to MEDDAC/MEDCEN within Systems Classification priority Classes A, B and C. .

n. Public Affairs support. Host installation Public Affairs Officers will

(1) Act as release authority for public information on the installation, to include release of information authorized by AR 360-5 and AR 340-17. . . .

(3) Provide Command Information (CI) assistance, to include post news-paper support and CI fact sheets, to MEDDAC/MEDCEN facilities.

(4) Coordinate with MEDDAC/MEDCEN CI personnel to provide closed circuit radio/television CI programming to MEDDAC/MEDCEN facilities when and where feasible.

Section III

MEMORANDUM OF UNDERSTANDING
BETWEEN
THE DIRECTOR, DEFENSE LOGISTICS AGENCY (DLA)
AND
HEADQUARTERS, UNITED STATES ARMY HEALTH SERVICES COMMAND

1. The following Memorandum of Understanding is established between US Army Health Services Command (HSC) and the Director, Defense Logistics Agency (DLA)
2. In accordance with this Memorandum of Understanding, the USAEHA, an activity under the command jurisdiction of HSC and located at Aberdeen Proving Ground, MD 21010 (Edgewood Area), will provide survey and consultative services in support of the DLA's environmental quality and occupational health programs. These services will include routine and special surveys and related consultation available from the USAEHA's resources. .

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